

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 2, 2016

[Redacted]

IBR Case Number:	CB16-0000187	Date of Injury:	04/18/2015
Claim Number:	[Redacted]	Application Received:	02/09/2016
Assignment Date:	02/26/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	04/30/2015 – 05/14/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	DRG 981		

Dear [Redacted]:

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above Workers’ Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$195.00 for the review cost and \$4,967.36in additional reimbursement for a total of \$5,162.36. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$5,162.36** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, M.D., M.P.H.
Medical Director

cc: [Redacted]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- Official Medical Fee Schedule
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: Title 8, CCR, Chapter 4.5, Subchapter 1, 9789.22, 9789.23, 9789.24

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider seeking \$9,043.14 in additional remuneration for DRG 981 performed from 04/30/2015 – 05/14/2015.**
- In-Patient documentation not received for IBR. Special Qualifying DRG cannot be determined.
- **CCR § 9789.22.** Payment of Inpatient Hospital Services (f)(1)(A)(2) (2) If costs exceed the outlier threshold, the case is a cost outlier case. The additional allowance for the outlier case equals $0.8 \times (\text{costs} - \text{cost outlier threshold})$.
- Total billed charges: \$676,698.32
- DRG 0981 Service Intensity Weight: 4.9968
- Provider hospital specific composite factor: 14152.57
- Provider cost-to-charge ratio: 0.189
- Provider hospital specific outlier factor: 36825.71
- Inpatient Hospital Fee Schedule Amount: **\$84,861.07**
 $4.9968 \times 1.2 \times 14152.57 = \$84,861.07$
- Charges reduced to costs: **\$127,895.98**
 $\$676,698.32 \times 0.189 = \$127,895.98$
- Provider indicates Outlier Threshold = \$116,592.05. CCR § 9789.22. Payment of Inpatient Hospital Services (f)(1)(A) Outlier threshold = Inpatient Hospital Fee Schedule payment amount (**\$84,861.07**) + hospital specific outlier factor (**36825.71**) + any new technology pass-through payment determined under Section 9789.22(h) (**None**) + any additional allowance for spinal devices under Section 9789.22(g)(2)) (**None**).
 - DRG 981 does not qualify for any additional allowances.
 - Documentation does not indicate “new technology.”
 - Outlier Threshold = **\$121,686.78**
 - $\$84,861.07 + 36825.71 = \$121,686.78$
- Per CCR 9789.22 (f)(2), “If costs exceed the outlier threshold, the case is a cost outlier case. The additional allowance for the outlier case equals $0.8 \times (\text{costs} - \text{cost outlier threshold})$.”
- **Based on review of CCR § 9789.22 (f) this is a Cost Outlier Case.**
- Cost \$127,895.98 – Outlier Threshold \$121,686.78 = \$6,209.20 x 0.8 = **\$4,967.36**
- **OMFS DRG 918 Allowable: \$84,861.07 + \$4,967.36 = \$89,928.43**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for DRG 918.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: DRG 918

Date of Service: 04/30/2015 – 05/14/2015					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
DRG 918	\$676,698.32	\$84,861.07	\$9,043.15	\$89,928.43	OMFS– Reimbursed Amount = \$4,967.36 Due Provider

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