

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 28, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000527	Date of Injury:	06/13/2007
Claim Number:	[REDACTED]	Application Received:	04/01/2016
Assignment Date:	04/20/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/13/2015 – 02/21/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	DRG 460 (including Rev Code 0274)		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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 4603.6(f).

Sincerely,

[REDACTED], M.D., M.P.H.
Medical Director

Cc: [REDACTED]
[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
- Authorization
- OMFS

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 additional remuneration for DRG 460 and Rev Code 0274 for date of service 02/13/2015 through 02/21/2015.**
- EOR 01/25/2016, Receive Date 11/17/2015, Processed 01/25/2016, ICN# 2077-9912030, indicates a “second review,” indicating, “**based on additional information from the claims examiner**, we are recommending further payment be made for the above noted code/codes.”
 - Codes references relate to room-board
- EOR 03/22/2015 reflects “received 03/22/2015, processed 03/22/2015”
 - “second review”
- EOR 03/25/2015 reflects “received 03/25/2015, processed 03/25/2015”
 - “denied services provided outside of designated network”
- Authorization dated 10/12/2015 “approved by physician advisor” indicates “inpatient stay unspecified number/approved.”
 - Authorization does not indicate DRG
 - Authorization does not indicate diagnoses
 - Authorization does not indicate surgical services authorized
 - Authorization does not indicate if Inpatient Stay is related to surgical procedure
 - DRG 460 (Spinal Fusion Except Cervical W/O MCC)
 - Authorization indicates: “additional services require separate review.”
 - **Authorization indicates: “3 days” authorized.**
 - **In- Patient Admit 02/13/2015** for “worsening BLE pain and urinary incontinence and found to have cord compression.”
 - **Date of Operation 02/16/2015 – 1 (one) day after authorized days.**
 - Reference # 1607359
 - Page 2 of Authorization indicates RFA enclosed
 - **Request for Authorization not submitted for IBR.**
- Request For Authorization was not submitted for review.
 - Unable to determine services approved by the Physician Advisor referenced on the 10/21/2015 Authorization, Reference # 1607359
 - Authorization indicates “in-patient stay” but fails to reflect the type of stay authorized.
 - Page 2 of Authorization indicates RFA enclosed, however, the Request for Authorization was not submitted for IBR.
- UB-04 line items reflect services from 02/13/2015 through 02/21/2015.
 - Authorization specifies “3 days”
- Authorization specifies 3 days. Inpatient Service Dates are 02/13/2015 through 02/21/2015
 - Rev Code 0274 representing DME L0464 and L2830 reflects DOS 02/17/2015, which is **past the allowable (3) days authorized**, is not included in DRG 460.
- Although DRG 460 (Spinal Fusion Except Cervical W/O MCC) has an average length of stay of 3.1 days, **the Authorization does not indicate the type of in-patient stay (DRG) authorized.** The RFA was not submitted for review. Due to the ambiguity of the Authorization, the authorized 3 day in-patient stay could not be clarified and validated with the services relevant to submitted DRG 460. The Final EOR appears to be 01/25/2016, ICN#

2077-9912030, where additional information was **provided by the Claims Examiner** to the **Payor** resulting in a payment of \$18,180.60 to the Provider for the following:

- Room-Board/Semi
 - UB-04 indicates “4” units Rev Code 0120: Room-Board/Semi
- The Maximum Allowable for REV Code 120 (only) equates to less than reimbursed amount (MA = BA x CCR x 1.26).
- Authorization indicates: “3 days” authorized.
 - In- Patient Admit 02/13/2015 for “worsening BLE pain and urinary incontinence and found to have cord compression.”
 - Date of Operation 02/16/2015 – 1 (one) day after authorized days.
- It appears the Claims Administrator reimbursed the Provider for 3 in-patient days unrelated to Surgical Services performed 02/16/2015 - one day after authorized days.
- DRG weights range from 0.4260 to 25.3518. For this case, a per diem rate for 3 days of in-patient stay cannot be calculated as the Authorization does not indicate the type of in-patient stay authorized; corresponding DRG weight cannot be determined and a periderm rate cannot be calculated. A Maximum Allowable cannot be determined due to the ambiguity of the authorization and inability to clarify authorized services with the RFA as the RFA was not submitted for review.
- A Per Diem contractual rate is not indicated as the Provider specified “no PPO contract was utilized.”
- **Based on the aforementioned documentation and guidelines, additional reimbursement could not be established for DRG 460 and Rev. Code 0274.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: DRG 460 & Rev Code 0274

Date of Service: 02/13/2015 through 02/21/2015					
In Patient					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers’ Comp Allowed Amt.	Notes
DRG 460 & Rev. Code 0274	\$313,949.67	\$18,180.60	\$29,287.61	\$18,180.60	Refer to Analysis

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