

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 18, 2014

[Redacted]
[Redacted]
[Redacted]

| | | | |
|------------------------------|---------------------|------------------------------|------------|
| IBR Case Number: | CB14-0000904 | Date of Injury: | 06/27/2013 |
| Claim Number: | [Redacted] | Application Received: | 06/24/2014 |
| Claims Administrator: | [Redacted] | Assignment Date: | 07/23/2014 |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | Outpatient Services | | |

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]
[Redacted]

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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: Outpatient Hospital Fee Schedule

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 is dissatisfied with reimbursement of outpatient services. Provider's dispute states "Hospital is a Long Term Acute Care Hospital. Enclosed is an Order by the Administrative Director, dated October 17, 2011 which states that under Title 8, the California Code of Regulations section 9789.22 (j) (5) exempts long term care hospitals from the maximum reimbursement formula set forth in subdivision (a) and are paid on a reasonable cost basis."
- In accordance with Hospital's request and CMS' approval, Hospital voluntarily terminated their CMS certification number 050762 (acute care hospital) effective April 30, 2009, and became a long term acute care hospital (LTCH) CMS certification number 052054 effective as of May 1, 2009. The Order of the administrative director removes Hospital listed as CMS provider number 050762 from Title 8, California Code of Regulations section 9789.23 for discharges on or after May 1, 2009.

- Provider states they are “Long Term Care Hospital”. Provider billed services for date of service 02/28/2014 on an outpatient basis. Provider’s operative note dated February 28, 2014 states “Plan: He will be discharged today, followed up in 10 days, and start therapy in four weeks.”
- Claims Administrator reimbursed \$6125.36 and indicated “Provider is billing their services as outpatient services in which the outpatient ruling does not list long term care hospitals as being exempt from the fee schedule. They are exempt from IPPS, but not OPSS in which case the OPSS rules would still apply to this bill. Additionally, the provider is within the PPO network and subject to further reductions.”
- Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers’ Compensation orders that Title 8, California Code of Regulations, sections 9789.30 and 9789.31, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, is amended to conform to CMS’ hospital outpatient prospective payment system (OPSS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services’ (CMS) Hospital Outpatient Prospective Payment System (OPSS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. The adopted payment system addenda by date of service are found in the Title 8, California Code of Regulations, and Section 9789.39(b). Based on the adoption of the CMS hospital outpatient prospective payment system (OPSS), CMS coding guidelines and the hospital outpatient prospective payment system (OPSS) were referenced during the review of this Independent Bill Review (IBR) case.
- Long-term care hospitals (LTCHs) furnish extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, that need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average inpatient length of stay greater than 25 days.
- Based on information received, no evidence leads to Provider’s outpatient services to be reimbursed at “Reasonable Cost”. Claims Administrator was correct to reimburse based on the OPSS and therefore, additional reimbursement is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of outpatient services is not warranted.

| Date of Service: 2/28/2014 | | | | | | | |
|----------------------------|-----------------|--------------|----------------|----------------|------------------|----------------------------|---|
| Outpatient Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Assist Surgeon | Multiple Surgery | Workers' Comp Allowed Amt. | Notes |
| Outpatient | \$36026.17 | \$6125.36 | \$29897.81 | N/A | N/A | \$0.00 | DISPUTED SERVICE: Additional reimbursement not recommended. |

Copy to:

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