

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

08/20/2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000055	Date of Injury:	01/03/2013
Claim Number:	[Redacted]	Application Received:	01/14/2015
Assignment Date:	02/10/2015		
Claims Administrator:	[Redacted]		
Dates of Service:	11/01/2013 – 11/08/2013		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	Revenue Code 636		

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 \$18,261.10 in additional reimbursement for a total of \$18,456.10. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$18,456.10 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 30 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,

Paul Manchester, MD
Medical Director

cc: [Redacted]
[Redacted]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- January 14, 2015 letter from [REDACTED] entitled DWC-IBR Request, signed by [REDACTED];
- Maximus CA WC 1.2.5.0.12 Request for Independent Bill Review;
- State of California, Division of Worker's Compensation Request for Independent Bill Review Form completed and signed by [REDACTED], January 14, 2015;
- Proof of Service of the IBR request with supporting Documents dated January 14, 2015, signed by [REDACTED];
- A packet entitled "Original Bill for \$114,312.98" for date of service 1/11/13 through 1/18/13, with medical reports, consisting of approximately 115 pages;
- Original EOR from Rising Medical Solutions packet containing 11 pages, counting the title page;
- Third packet of documents entitled "Request for Second Review with Supporting Documents," containing approximately 36 pages, including the cover sheet;
- Another packet entitled "EOR by Rising Medical Solutions After Second Review" December 16, 2014. The packet contains four pages, including cover sheet;
- Another packet entitled "Contract Between Tenet California Regional Twin Cities Community Hospital and Prime Health Services, Inc." Packet containing approximately 19 pages, including the cover sheet;
- The defendant's Letter of February 2, 2015, addressed to Maximus Federal Services and attachment, which included Explanation of Review, dated December 30, 2013, January 15, 2014, March 7, 2014, March 31, 2014, May 16, 2014, November 21, 2014, December 16, 2014, January 12, 2015;
- Letters from the carrier to Twin Cities dated March 25, 2014 and May 15, 2014;
- Letter from provider dated January 16, 2014;
- Official Medical Fee Schedule;
- National Correct Coding Initiatives; and
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

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 seeking additional contractual remuneration for line item Revenue Code 636, billed as part of DRG 920, Inpatient Services, during LOS 11/01/2013 – 11/08/2013**
- **Revenue Code 636** Description: Drugs Requiring Detailed Coding
- EORs reflect the Claims Administrator reimbursement rationale as follows:
 - Reimbursement has been calculated based on a DRG Allowance
 - The Charge Exceeds the Fee Schedule Allowance. The Charge has been adjusted to the scheduled allowance

- UB-04 reflects DRG 920 with **Revenue Code 636 and a line item charge of \$33,535.94**
- **8 C.C.R. § 97925.9 (b)(3)** A statement that the claims administrator may dispute both eligibility of the request for independent bill review under subdivision (a) and the provider's reason for requesting independent bill review by submitting a statement with supporting documents, and the Independent Bill Review Regulations
- IBR Opportunity to Dispute Eligibility communication mailed to Claims Administrator on 01/22/2015
- **8 C.C.R. section 9792.5.0** et seq. (Approved 02/12/2014) 12 Administrative Director or his or her designee must receive the statement and supporting documents within fifteen (15) calendar days of the date designated on the notification, if the notification was provided by mail, or within twelve (12) calendar days of the date designated on the notification if the notification was provided electronically
- IBR Response from Claims Administrator Received February 11, 2015; 21 days post 01/22/2015 IBR Opportunity to Dispute Eligibility Communication
- Records received by the Provider for IBR regarding DRG 920, dates of service 11/01/2013 – 11/08/2013, include the following copies:
 - 1) IBR Request by contracted agent of Provider
 - 2) IBR Application
 - 3) Proof of Service
 - 4) Original Bill
 - 5) Medical Records pertinent to LOS
 - 6) EOR's processed: 12/30/2013 & 03/31/2014: reflecting reimbursement \$8,999.56
 - 7) Letter from Claims Administrator addressing "appeal request" dated 03/25/2014
 - 8) Letter from Provider requesting "formal appeal" dated 01/16/2014
 - 9) Letter from Contracted Agent to Claims Administrator requesting "re-consideration."
 - 10) Correspondence entitled "DRG Calculation Form- Cost Outlier Case"
 - 11) Signed Contractual Agreement between the Provider and the Claims Administrator, reflects "Effective Date" as "August 1, 2008"
- Records received by the Claims Administrator for IBR regarding DRG 920, dates of service 11/01/2013 – 11/08/2013, include the following copies:
 - 1) Communication to the Provider from the Claims Administrator dated 03/25/2014 & 05/15/2014 confirms receipt of "appeal request" for "dates of service "11/01/2013 – 11/08/2013"
 - 2) EOR's 12/30/2013, 01/15/2014, 03/07/2014, 03/31/2014, 05/16/2014, 11/21/2014, 12/16/2014 & 01/12/2015
 - 3) Communication indicates "formal appeal," dated 01/16/2014 from Provider
 - 4) Communication from Contracted Agent of Provider requesting "re-consideration"
 - 5) Copy of IBR Opportunity to Dispute Edibility Letter, dated 01/22/2015
 - 6) Cover Letter from Claims Administrator to IBR dated 02/02/2015
- Records received by the Claims Administrator for IBR regarding DRG 920, dates of service 11/01/2013 – 11/08/2013, did not include the following copies:
 - 1) In-patient records
 - 2) Contractual Agreement.
- EOR's for the following "processed" dates were reviewed: 12/30/2013, 01/15/2014, 03/07/2014, 03/31/2014, 05/16/2014, 11/21/2014, 12/16/2014 & 01/12/2015

- EOR Processed 12/16/2014 & 01/12/2015, reflect a ‘Network Reduction’ of \$0.00 with a Total Allowance that included the previously deducted network allowance of \$183.66, with a Total Allowance of \$9,183.22, for DRG 920. However, both EOR’s reflect a reimbursement of “\$0.00,” for Revenue Code 636
- The Claims Administrator’s total Allowance for DRG 920 is \$9,183.22
- **Contractual agreement “Schedule B.” page 13** indicates the following:

“For All Inpatient and Outpatient Covered Services, Provided Workers’ Compensation Cases: Each Participating (PPO) Facility agrees to accept ninety-eight percent (98%) of the **State mandated** fee schedule **with the exceptions of REV codes 274, 275, 276, 278, 634-636** which **shall be paid at 55% of charges instead of per the state fee schedule.**”

- The OMFS is the State Mandated fee schedule indicated in the Contractual Agreement between the Provider and the Claims Administrator
- Pursuant to **§9789.22 of the OMFS** for services on or after March 2013, Payment for Hospital Services, the calculations for DRG 920, is as follows:

$$\text{Wt. } 0.9693 \times \text{Composite } 7895.06 \times \text{WC } 1.2 = \mathbf{\$9,183.22}$$

- EOR’s indicate the Provider was reimbursed 100 % OMFS @ **\$9,183.22**
- **Labor Code § 4611 states:** (a) When a contracting agent sells, leases, or transfers a health provider’s contract to a payor, the rights and obligations of the Provider shall be governed by the underlying contract between the health care provider and contracting agent
- **LC § 5307.11** – “the medical fee schedule shall not apply to the contracted reimbursement rates.” California State Assembly Bill 1177 amended the Labor Code effective January 1, 2002 to add §5307.11:
 - **LC § 5307.11 states:** A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, **the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.**
- **The Contractual Agreement**, indicates reimbursement for DRG 920, is as follows:
 - A. $\text{Wt. } 0.9693 \times \text{Composite } 7895.06 \times \text{WC } 1.2 = \$9,183.22 \times 98 \% = \$8,999.56$
 - B. **Revenue Code 636** and a **line item charge of \$33,535.94 – 55% = \$18,444.76**
 - A) $\$8,999.56 + \text{B) } \$18,444.77 = \mathbf{\$27,444.33}$
 - $\$27,444.33 - \text{Reimbursed Amount } \$9,183.22 = \mathbf{\$18,261.10}$

CONCLUSION

As discussed above, the contractual agreement states that “For All Inpatient and Outpatient Covered Services, Provided Workers’ Compensation Cases: Each Participating (PPO) Facility agrees to accept ninety-eight percent (98%) of the State mandated fee schedule with the exceptions of Rev codes 274, 275, 276, 278, 634-636 which shall be paid at 55% of charges instead of per the state fee schedule.” In this

case, the State mandated fee schedule for DRG 920 is \$9,183.22. The facility is due 98% of this amount, which equals \$8,999.56. The contractual agreement also states that Rev Code 636 is paid at 55% of billed charges. The billed amount for Rev Code 636 was \$33,535.94. The facility is due 55% of this amount, which equals \$18,444.76. These two charges added together total \$27,444.33. The amount that was actually paid was \$9,183.22, a difference of \$18,261.10. **Based on the aforementioned documentation and guidelines, additional reimbursement in the amount of \$18,261.10 is indicated for Revenue Code 636 pursuant to LC § 5307.11.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code Revenue Code 636

Date of Service: 11/01/2013 – 11/08/2013.						
In-Patient Hospital						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
Revenue Code 636	\$33,535.94	\$0.00	\$18,261.10	N/A	\$18,444.76	PPO Contract \$18,261.10 Due Provider
DRG 920	N/A	N/A	N/A	N/A	N/A	Service Not in Dispute

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