

MAXIMUS FEDERAL SERVICES, INC.

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

Independent Bill Review Final Determination Reversed

6/25/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000040	Date of Injury:	8/17/2013
Claim Number:	[REDACTED]	Application Received:	1/13/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	8/17/2013 – 8/24/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	DRG 494		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/3/2014, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$15,391.98, for a total of \$15,726.98.**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:

The following evidence was used to support the decision:

- 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 or negotiated contract: PPO Contract
- Other: OMFS Inpatient Hospital Fee Schedule

Supporting Analysis:

The dispute regards the payment amount for inpatient hospital services billed with DRG 494. The Claims Administrator reimbursed the Provider \$15,559.79 with the following explanation "The charge was adjusted to comply with the rate and the rules of the contract indicated. The charge exceeds the Official Medical Fee Schedule allowance. The amount paid reflects a fee schedule reduction."

The Provider is disputing the billed Inpatient Hospital services qualify for an outlier payment and the additional amount was not paid.

Per the Official Medical Fee Schedule Inpatient Hospital Fee Schedule, "Cost outlier case" means a hospitalization for which the hospital's costs, as defined in subdivision (f), exceeds the cost outlier threshold. "Costs" means the total billed charges for an admission, excluding non-medical charges such as television and telephone charges, charges for Durable Medical Equipment for in home use, charges for implantable medical devices, hardware, and/or instrumentation reimbursed under subdivision (g) of Section 9789.22, multiplied by the hospital's total cost-to-charge ratio and except for cases reimbursed under section 9789.22(g)(1), plus documented paid spinal device costs, net of discounts and rebates, plus any sales tax and/or shipping and handling charges actually paid.

Per the Official Medical Fee Schedule Inpatient Hospital Fee Schedule 9789.22 (f)(1) Cost Outlier cases. Inpatient services for cost outlier cases shall be reimbursed as follows:

Step 1: Determine the Inpatient Hospital Fee Schedule maximum payment amount (DRG weight x 1.2 x hospital specific composite factor).

Step 2: Determine costs. $Costs = ((total\ billed\ charges - charges\ for\ spinal\ devices) \times total\ cost\ to\ charge\ ratio) + documented\ paid\ spinal\ device\ costs, net\ of\ discounts\ and\ rebates, plus\ any\ sales\ tax\ and/or\ shipping\ and\ handling\ charges\ actually\ paid.$

Step 3: Determine outlier threshold. $Outlier\ threshold = (Inpatient\ Hospital\ Fee\ Schedule\ payment\ amount + hospital\ specific\ outlier\ factor + any\ new\ technology\ pass-through\ payment\ determined\ under\ Section\ 9789.22(h) + any\ additional\ allowance\ for\ spinal\ devices\ under\ Section\ 9789.22(g)(2)).$ If costs exceed the outlier threshold, the case is a cost outlier case. The additional allowance for the outlier case equals $0.8 \times (costs - cost\ outlier\ threshold).$

The Operative Reports documented the following procedures: right tibia/fibula external fixator application performed on 8/17/2013; Revision, external fixation with intramedullary fixation of the fibula only tibia plafond performed 8/20/2013. The implants used were Stryker Hoffman III large external fixator 11 mm bars, 5-0 half pins and 3 mm stainless steel flexible nail.

The Provider billed a total of \$335,308.36 for the inpatient services for date of service 8/17/2013 thru 8/24/2013. The total costs were determined by excluding any charges for implantable medical devices from the total billed charges, then multiplied by the Hospital's Cost-to-Charge Ratio (.200). The Provider billed a total of \$31,581.84 for revenue code 272 (supply/implant). Based on the above calculation, the costs were determined to be \$60,745.30 ($335,308.36 - 31,581.84 = 303,726.52 \times .200$).

The Outlier Threshold was calculated on the Inpatient Hospital Fee Schedule payment amount (15,877.35) plus the hospital specific outlier factor (25,235.34). The Outlier Threshold amount was determined to be \$41,112.69.

The Hospital's costs exceed the outlier threshold amount; therefore, the billed inpatient services qualify as an outlier threshold case and additional reimbursement is warranted.

The additional allowance was determined based on the following calculation: $0.8 \times (\text{costs } 60,745.30 - \text{outlier threshold } 41,112.69) = \$19,632.61 = \$15,706.09$.

The additional reimbursement for the Inpatient Services was calculated based on the Outlier Threshold Case formula minus any PPO discount.

The additional reimbursement of \$15,391.98 is warranted per the Official Medical Fee Schedule Inpatient Hospital service billed with DRG 494.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
DRG 494	\$20,344.01	\$30,951.77	\$15,559.79	\$15,391.98	PPO Contract

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for DRG code 494 (\$15,391.98) for a total of \$15,726.98.

The Claims Administrator is required to reimburse the provider \$15,726.98 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).

Sincerely,

██████████ RHIT

Copy to:

██████████
██████████
██

Copy to:

██
██
██