

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 16, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001421	Date of Injury:	01/20/2015
Claim Number:	[Redacted]	Application Received:	08/24/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	01/28/2015 – 02/13/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	DRG 946		

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 \$117,617.95 in additional reimbursement for a total of \$117,812.95. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$117,812.95 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 4603.6(f).

Sincerely,

Paul Manchester, MD, MPH
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
- Official Medical Fee Schedule
- Negotiated contracted rates: PPO Contract Agreement
- National Correct Coding Initiatives

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 DRG 946, REHABILITATION W/O CC/MCC
- Claims Administrator reimbursed DRG according to IPPS with rationale “This bill was paid at a reasonable cost basis using DRG 946. No PPO discount was taken. We have verified that this bill was processed correctly per their contract with the Network. A copy of their contract is being sent to you under separate cover directly from the Network.”
- Copy of contract was received for this review. The Payment clause states “the Contract Hospital shall be paid by the respective Payor at the rates set forth in Appendix A...For payment purposes, the inpatient per diem rate shall apply for any Participant who has been admitted as an inpatient or is occupying a bed at midnight...”
- ‘Amendment to the Contract’ shows “The parties to the above-entitled contract hereby amend Appendix A of the Hospital Agreement.” Further in the contract states “To be effective for admissions on or after October 1, 1996: **Outlier Provision: If charges for a single uninterrupted patient stay are greater than \$15,450, reimbursement for that stay only will be at a 30% discount form charges in lieu of the per diem rate.”
- §5307.11: 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.

- Provider billed DRG 946 with a total of \$186,110.95.
- Based on aforementioned guidelines, additional reimbursement of DRG 946 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of DRG 946

Date of Service: 01/28/2015 – 02/13/2015					
Inpatient Rehabilitation					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
DRG 946	\$186110.95	\$12,659.72	\$117617.95	\$130,277.67	Reimbursement in the amount of \$117,617.95 due to Provider based on PPO contract agreement.

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