

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
- 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 464 for dates of service 06/11/2015 – 06/16/2015.**
- The Claims Administrator’s reimbursement rational for DRG 464 indicates “Fee Schedule Allowance.”
- Opportunity to Dispute communicated to Claims Administrator on 11/5/2015; response not yet received.
- Provider indicates “No PPO Contract.”
- **Pursuant to Labor Code section 5307.1(g)(2)**, the Acting Administrative Director of the Division of Workers’ Compensation orders that Title 8, California Code of Regulations, sections **9789.23, 9789.24**, and 9789.25 pertaining to Inpatient Hospital Fee Schedule in the Official Medical Fee Schedule, are adjusted to conform to the final rule of August 22, 2014 and the correction notice of October 3, 2014, published in the Federal Register, which changes the Medicare payment system. Amended section 9789.23 reflects the changes to the Composite Rate, Hospital Specific Outlier Factor, and Cost to Charge Ratio for the listed California inpatient hospitals. Amended section 9789.24 reflects Medicare’s changes to the Relative Weights and Geometric Mean Length of Stay for the listed Medicare Severity diagnosis-related groups.
- The Administrative Director (AD) order (above) adjusts the inpatient hospital section of the OMFS to conform to changes in the 2015 Medicare payment system as required by Labor Code section 5307.1. The effective date of the changes is March 5, 2015. Although 2014 update factors were adopted in the OMFS rulemaking with the same effective date of March 5, 2015, the 2015 update factors adopted by the AD order should be used for dates of discharge on or after March 5, 2015.
- Regulation effective March 5, 2015 (sections 9789.20–9789.25, Title 8, California Code of Regulations, § 9789.23, 9789.24: DRG Relative Weight 3.0085, Hospital Composite Factor 14152.57 = \$51,093.61.
- **Based on the In-Patient documentation and OMFS guidelines, additional reimbursement is indicated for DRG 464.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: DRG 464

Date of Service: 06/11/2015 – 06/16/2015.						
In-Patient						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
DRG 464	\$277,407.90	\$33,054.18	\$18,054.18	1	\$51,093.61	\$18,039.43 Due Provider Refer to Analysis

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