

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
- PPO Contract

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 contractual HOPPS reimbursement for Revenue Codes: 250, 260, 300, 301, 320, 352, 0450 and 636 performed 9/12/2014 – 9/13/2014.**
- Claims Administrator reimbursement rational: “The charge was adjusted to comply with the rate and the rules of the contract indicated.”
- UB-04, Bill Type 131, Rev Codes: 250, 260, 300, 301, 320, 352, 0450 and 636, DOS: 9/12/2014 – 9/13/2014.
- **Contractual Agreement** states the following regarding “occupationally ill/injured employees”: In the case of Outpatient Services rendered to occupationally ill/injured employees, the reimbursement shall be the contract rate (**10% discount form billed charges**). It is noted that the In-patient contractual agreement is “payable under guidelines established under any state law...” However, the contract clearly indicates “10 %” of billed charges are reimbursable for Outpatient Services.
- **Pursuant to LC § 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.**
- **§ 9792.5.7 (b)** Unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code shall be resolved before seeking independent bill review.
- Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for REV Codes 250, 260, 300, 301, 320, 352, 0450 and 636.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: REV Codes 250, 260, 300, 301, 320, 352, 0450 and 636

Date of Service: 9/12/2014 – 9/13/2014. HOPPS						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
REV Codes 250, 260, 300, 301,	\$9,073.50	\$1,762.74	\$6,403.41	1	\$6,403.71	PPO Contract

320, 352, 0450 and 636						
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