

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 5, 2016

[Redacted]

IBR Case Number:	CB16-0000277	Date of Injury:	07/27/2015
Claim Number:	[Redacted]	Application Received:	02/19/2016
Claims Administrator:	Liberty Mutual		
Date(s) of service:	07/27/2015 – 08/05/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	DRG 494		

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 \$19,788.19 in additional reimbursement for a total of \$19,983.19. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$19,983.19 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

[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
- National Correct Coding Initiatives
- Other: **§9789.22 (f) of the CCR Payment of Inpatient Hospital Services**

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 outlier reimbursement for DRG 494 for dates of service 07/27/2015 – 08/05/2015
- Claims Administrator reimbursed DRG 494 according to Inpatient Hospital Fee Schedule maximum payment amount (DRG weight x 1.2 x hospital specific composite factor).
- PPO contract received states: “Notwithstanding contract rates contained herein/ the amount payable under the terms of. this Contract shall not exceed total billed charges and/ for services rendered to occupationally ill/injured employees shall not exceed the amount payable under guidelines established under any State law or regulation pertaining to health care services for occupationally ill/injured employees.”
- **Based on review of section 9789.22 (f) of the CCR:**
- Total billed charges: \$261,841.02
- DRG 494 Weight: 1.5397
- Geometric mean LOS: 2.7
- Actual LOS: 9
- Provider hospital specific composite factor: \$8,758.94
- Provider cost-to-charge ratio: .269
- Provider hospital specific outlier factor: \$29,516.50
- Inpatient Hospital Fee Schedule Amount: \$16,183.37
 $1.5397 \times 1.2 \times 8758.94 = \$16,183.37$

- Charges reduced to costs: **\$70,435.23**
 $\$261,841.02 * .269 = \$70,435.23$
- Cost outlier threshold: $\$16,183.37 + \$29,516.50 = \mathbf{\$45,699.87}$
- **Per CCR 9789.22 (f)(2), “If costs exceed the outlier threshold, the case is a cost outlier case.** The additional allowance for the outlier case equals $0.8 \times (\text{costs} - \text{cost outlier threshold})$. This case qualifies for additional cost outlier reimbursement.
 $(\text{Cost } \$70,435.23 - \text{cost outlier threshold } \$45,699.87) \times .8 = \$19,788.29$
- Total reimbursement: $\$16,183.37 + \$19,788.29 = \$35,971.66$

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of DRG code 494

Date of Service: 07/27/2015 – 08/05/2015					
Inpatient Hospital					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers’ Comp Allowed Amt.	Notes
494	\$261,841.02	\$16,183.47	\$19,788.19	\$35,971.66	\$19,788.19 Due to Provider

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]