

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: 100% OMFS
- Labor Code section 5307.1(g)(2)
- Other: Title 8, CCR, Chapter 4.5, Subchapter 1, 9789.21, 9789.22, 9789.24

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 \$76,372.96 in additional remuneration for In-Patient Hospital Services billed under DRG 511 for services dates 03/17/2014 – 04/08/2014.**
- Documentation submitted as Initial EOR, **Date Bill Received: 04/17/2014**, ICN# 2014126028700, reflects reimbursement amount of \$15,116.72, Check# 0110946977, indicating “contractual” obligation utilized in determination of reimbursement.
- Documentation submitted as Second EOR, ICN# 20141260287002, reflects denial of charges due to untimely filing.
 - SBR Application and accompanying letter reflects a date of 09/26/2014, which is 10 days less than 90 day filing deadline set forth in CCR § 9792.5.5; SBR was filed timely.
- Opportunity to Dispute Eligibility communicated with the Claims Administrator on 12/29/2014; response not received prior to initial case assignment date of 01/20/2015.
- Medical Records indicate Injured Worker presented to Critical Care Trauma Unit on 03/17/2014 s/p 20 foot fall with possible LOC sustaining “severe lateral compression fracture of the pelvis with active bleeding, closed radius fracture and blunt trauma to the chest” with subsequent transfer to the Intermediate Care Trauma Unit on 03/19/2014 until in-house transfer to Rehab from 04/05/2014 until discharge of 04/08/2014.

- **For inpatient hospital discharges on or after Mar. 15, 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, section 9789.24, pertaining to Inpatient Hospital Fee Schedule in the Official Medical Fee Schedule, is adjusted to conform to the final rule of August 19, 2013 and the corrections of October 3, 2013, January 2 and 10, 2014, and the interim final rule of October 3, 2013, published in the Federal Register, which changes the Medicare payment system. 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.
- **Title 8, California Code of Regulations § 9789.22. (2)**
 - (A) When an acute care patient is discharged to a post-acute care provider which is a rehabilitation hospital or **distinct part rehabilitation** unit of an acute care hospital or a long-term hospital, and the patient's discharge is assigned to one of the qualifying DRGs as specified in the Federal Register, payment to the transferring hospital shall be made as set forth in Section 9789.22(j)(1). See Section 9789.25(b) for the Federal Register reference that contains the **qualifying DRGs** for a given discharge.
 - (B) When an acute care patient is discharged to a post-acute care provider and the patient's discharge is assigned to one of the qualifying special pay DRGs as specified in the Federal Register, the payment to the transferring hospital is 50% of the amount paid under Section 9789.22(a), plus 50% of the **per diem**, set forth in Section **9789.22(j)(1)** for each day, **up to the full DRG amount**.
- **Code Description: DRG 511** Shoulder, Elbow or Forearm Proc, Except Major Joint Procedure W/CC
- FY 2013 DRG Table 5 indicates DRG 511 is not a special pay DRG.
 - DRG Estimated LOS: 3.2
 - Documented LOS: 23
- **CCR § 9789.22 (o)** Unless otherwise provided by applicable provisions of this fee schedule, "Inpatient Hospital Fee Schedule maximum payment amount" is that amount determined by multiplying the DRG weight x hospital composite factor x 1.20 and by making any adjustments required in Section 9789.22.
 - OMFS DRG Calculations: 1.5894 Weight x 1.2 WC Multiplier x Composite 7925.79584447574 = **\$15,116.71**
- **EOR, Receive Date: 04/17/2014**, ICN# 2014126028700, reveals reimbursement amount of \$15,116.72, Check# 0110946977, reflecting the Claims Administrator **reimbursed the Provider the Full DRG amount** opposed to a per diem rate.
- The estimated length of stay for reported DRG 511 is 3.2 days. Documentation reflects **19.8 additional days of In-patient charges incurred** during reported DRG 511; 16.60 days over 3.2.
- **Title 8, CCR § 9789.21.** Definitions for Inpatient Hospital Fee Schedule (h) "Cost outlier case" means a hospitalization for which the hospital's costs, as defined in subdivision (f) exceeds the cost outlier threshold. (f) "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

