

## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 20, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-0001896	Date of Injury:	03/17/2014
Claim Number:	[REDACTED]	Application Received:	12/09/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	1/20/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	DRG 511		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.**

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:
- National Correct Coding Initiatives
- Other: §9789.22 Payment of Inpatient Hospital Services (2)(B)

## 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 511 for dates of service 3/17/2014 – 4/8/2014
- Claims administrator reimbursed DRG 511 in the amount of \$15116.72 indicating on the Explanation of Review “We are unable to recommend an additional allowance since this claim was paid in accordance with the states fee schedule guidelines”
- DRG 511 - SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC
- Documentation submitted details the injured worker’s Discharge Summary which states after arriving in the trauma unit on 3/17/2014 the patient was then admitted to the intensive care unit. Itemized billing shows patient as remaining in the intensive care unit his entire stay until being discharged to the RU on 4/8/2014.
- Provider documents “The Medicare Claims Processing Manual (Exhibit C) states unequivocally that **the transferring hospital may be paid a cost outlier payment** : C. Transfers from an IPPS Hospital to Hospitals or Units Excluded from IPPS that Fall within a DRG that is Subject to the Postacute Care Transfer Policy”
- Pursuant §9789.22 (2) (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. See Section 9789.25(b) for the Federal Register reference that contains the qualifying DRGs for a given discharge.

- Transfers from an IPPS Hospital to Hospitals or Units Excluded from IPPS - The full inpatient prospective payment is made to the transferring hospital when a patient is transferred to a hospital or unit excluded from IPPS. The receiving hospital is paid on the basis of reasonable costs or prospective payment. (See exceptions in the next section.)  
IPPS Transfers – Post-acute Care Transfers (Previously Special 10 DRG Rule) For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in 42 CFR 412.4(c), to one of the qualifying Diagnosis-Related Groups (DRGs) in the following section and the discharge is made under any of the following circumstances:
  - To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (under subpart B of 42 CFR 412). Some facilities excluded from IPPS are: Inpatient rehabilitation facilities and units, Long term care hospitals, Psychiatric hospitals and units, Children's hospitals, Cancer hospitals;
  - To a skilled nursing facility;
  - To home with a written plan of care for the provision of home health services and those services begin within three days after the date of discharge.
- Qualifying DRGs • The original qualifying DRGs for purposes of the previous section (IPPS Transfers – Post acute Care Transfers) are DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483. • Effective October 1, 2003, DRGs 263 and 264 are deleted from the post-acute care transfer policy. • Effective for discharges on or after October 1, 2003, the following DRGs were added to the policy: 12, 24, 25, 88, 89, 90, 121, 122, 127, 130, 131, 239, 277, 278, 294, 296, 297, 320, 321, 395, and 468
- DRG 511 is not a qualifying DRG for Special Pay and therefore does not qualify for outlier payment or per diem rate. Claims administrator reimbursed 100% of the DRG rate and owes no further reimbursement of DRG 511.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of DRG 511 is not recommended.

Date of Service: 3/17/2014 – 4/8/2014						
Inpatient Hospital Services						
Service Code	Provider Billed	Plan Allowed	Disputed Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
DRG 511	\$563582.74	\$15116.72	\$76372.97	N/A	\$15116.72	<b>DISPUTED SERVICE:</b> No further reimbursement is recommended.

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]