

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 2, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB13-0000773	Date of Injury:	06/18/2013
Claim Number:	[Redacted]	Application Received:	11/21/2013
Claims Administrator:	[Redacted]	Assignment Date:	10/29/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99070 (E0190)		

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,

[Redacted]
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: None
- National Correct Coding Initiatives
- Other: OMFS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

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 denial of CPT 99070-NU (E0190)
- Pursuant to Labor Code section 5307.1(g) (2), the Administrative Director of the Division of Workers' Compensation orders that the Durable Medical Equipment, Prosthetics, Orthotics, Supplies portion of the Official Medical Fee Schedule contained in title 8, California Code of Regulations, section 9789.60, is adjusted to conform to changes to the Medicare payment system that were adopted by the Centers for Medicare & Medicaid Services for calendar year 2013.
- Pursuant to the General Information and Instructions, Code 99070 is used to bill for separately reimbursable supplies and materials "By Report" (BR). Procedures without Unit Values ("By Report"), By Reports "are services which are unusual or variable. An unlisted service or one that is rarely provided unusual or variable may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are: complexity of symptoms; final diagnosis;

pertinent physical findings; diagnostic and therapeutic procedures; concurrent problems; follow-up care”

- Based on review of the Provider’s report submitted, at the beginning of report on page 1, information gathered from the injured worker includes: Back Complaints/Symptoms: “Patient’s complaint at this time is as follows: pain-back. Patient describes the symptom(s) as sharp and dull. She says it is mild. She reports having symptoms for 2 days. The frequency is intermittent. Context: filling ice to soda machine. The symptoms are exacerbated by rom. The symptoms are lessened by rest.” Nothing noted about the injured worker’s quality of sleep being compromised or lacking. Under Neck Complaints/Symptoms: “Patient’s complaint at this time is as follows: pain-neck. Patient describes the symptom(s) as sharp and dull. She says it is mild. She reports having symptoms for 2 days. The frequency is intermittent. Context: filling ice to soda machine. The symptoms are exacerbated by rom. The symptoms are lessened by rest.” Nothing noted about the injured worker’s quality of sleep being compromised or lacking. Provider states “symptoms are lessened by rest” not indicating a necessity for any supply such as a cervical pillow.
- Page 3 of the same report, Provider documents under Supplies: Pillow Cervical 16” x 24” Tri-Core, Quantity 1, HCPC E0190 was dispensed. Under Supply Comments, Provider documents “Cervical pillow can significantly reduce pain and significant improve the quality of sleep.” Based on the injured worker’s complaints and symptoms, there doesn’t seem to be a necessity for a cervical pillow and therefore the Claims Administrator was correct to deny CPT code 99070 (E0190).

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of code 99070 (E0190) is not warranted.

Date of Service: 6/20/13						
Durable Medical Equipment						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
99070-NU (E0190)	\$26.47	\$0.00	\$26.47	1	\$ 0.00	DISPUTED SERVICE: No reimbursement recommended.

Copy to:

██████████
 ██████████
 ██████████

Copy to:

██
 ██
 ██