

MAXIMUS FEDERAL SERVICES, INC.

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

Independent Bill Review Final Determination Reversed

7/2/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000798	Date of Injury:	7/20/2011
Claim Number:	[REDACTED]	Application Received:	11/27/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	1/18/2013 – 1/26/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	Revenue code 274 (Orthotic Device L4360 and L2830)		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/14/2014, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$1,219.94, for a total of \$1,554.94.**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:

The following evidence was used to support the decision:

- 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 or negotiated contract: OMFS
- Other: OMFS Inpatient Hospital Fee Schedule

Supporting Analysis:

The dispute regards the denial of an orthotic device (L0464 and L2830) billed as part of inpatient hospital services (DRG 460). The Claims Administrator reimbursed the Provider \$42,222.28 on the initial explanation of review and denied any additional allowance on the final explanation of review with the following explanation “This letter is in response to your request for reconsideration of additional payment. Our original review in accordance with the values found in Official Medical Fee Schedule (OMFS) section 9789.22.”

The Provider is disputing the denial of additional allowance for the Spinal Orthotic device (L0464 and L2830).

- **HCCPS L0464:** Ilso, triplanar control, modular segmented spinal system, four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
- **HCCPS L2830:** Addition to lower extremity orthosis, soft interface for molded plastic, above knee section

Per the Official Medical Fee Schedule (OMFS) Inpatient Services, the cost of durable medical equipment provided for use at home is exempt from the Inpatient Hospital Fee Schedule. The cost of durable medical equipment shall be paid pursuant to Section 9789.60. The HCCPS L0464 and L2830 are Orthotics and are reimbursable when billed by a Hospital under the OMFS DMEPOS fee schedule per Title 8, CCR, section 9789.22(k)(7). Items requiring a prescription the allowance shall not exceed OMFS rate of 120% of Medicare’s DMEPOS fee schedule or 120% of the documented paid cost (not to exceed 100% of documented paid cost plus \$250.00). The Provider submitted an invoice indicating the documented paid cost of the Spinal Orthotic (L0464 and L2830) or was \$1,016.62. The OMFS allowance for the HCCPS code L0464 and L2830 is \$1,756.72. The allowance of 120% of the documented paid cost is less than the OMFS allowance; therefore, the recommended reimbursement for the billed orthotic (L0464 and L2830) is 120% of the documented paid cost.

Per a review of the explanation of review (EOR), the Claims Administrator reimbursed the Provider for the billed inpatient services (DRG 460) based on the OMFS Outpatient Hospital Fee Schedule. However, the reimbursement did not include an allowance for the billed orthotic HCCPS L0464 and L2830; therefore, additional reimbursement is warranted for the HCCPS L0464 and L2830.

The reimbursement of \$1,219.94 is warranted per the OMFS Inpatient Hospital Services (L0464 and L2830).

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
L0464, L2830	\$1,016.62	\$1,219.94	\$0.00	\$1,219.94	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for HCPCS code L0464 and L2830 (\$1,219.94) for a total of \$1,554.94.

The Claims Administrator is required to reimburse the provider \$1,554.94 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).

Sincerely,

██████████, RHIT

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