MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Independent Bill Review Final Determination Reversed

9/15/2014

[redacted]

IBR Case Number:	CB13-0000882	Date of Injury:	3/16/2013
Claim Number:	[redacted]	Application Received:	12/16/2013
Claims Administrator:	[redacted]		
Date(s) of service:	6/10/2013 – 6/10/2013		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	E1399 LL		

Dear [redacted]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/21/2014, 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 $693.42 for a total of $1,028.42.**

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: CMS' Durable Medical Equipment, Prosthetics/Orthotics, and supplies (DMEPOS) Fee Schedule

Supporting Analysis:

The dispute regards the amount paid for Durable Medical Equipment (E1399 Modifier LL). The Provider was reimbursed $296.58 and is requesting additional reimbursement of $693.42.

The Claims Administrator based its reimbursement on E0745 for the billed HCPCS code E1399 with the explanation "Based on the available information."

• E1399: Durable Medical Equipment, miscellaneous
• Modifier LL: Lease/rental (use the LL modifier when DME equipment rental is to be applied against the purchase price)

The Provider is the manufacturer of the supplied Durable Medical Equipment (H-Wave Home Device). The DME equipment was billed using the HCPCS E1399. The HCPCS code E1399 is not listed on the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and supplies (DMEPOS) Fee Schedule. The cost of the item was documented on the invoice at $3,300.00. A written appeal was submitted with the documentation, the appeal indicated a monthly charge of $330.00 and purchase price of $3,300.00. The original bill submitted with the documentation indicated a billing for three (3) units of the billed HCPCS code E1399 Modifier LL. The documentation included a prescription for the H-wave Home Care system. The documentation included a report titled "Primary Treating Physician's Progress Report Addendum", which indicated the following Treatment Plan and Prescription: "Continued current treatment plan with the EWL H-Wave Homecare System for: 3 Months." The written authorization (Utilization Review) from the Claims Administrator dated 6/18/2013 indicated the following under UR Determination: "The prospective request for 3 month rental of H-Wave homecare system between 6/7/2013 and 8/13/2013 is certified."

The DME equipment was billed using the HCPCS E1399. The HCPCS code E1399 is not listed on the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and supplies (DMEPOS) Fee Schedule. A written appeal was submitted with the documentation. The appeal indicated a monthly charge of $330.00 and purchase price of $3,300.00. The Claims Administrator did not indicate on the explanation of review (EOR) or authorization a pre-negotiated fee arrangement of $296.58 or allowance of E0745. Therefore, the reimbursement of H-Wave unit billed using HCPCS E1399 Modifier LL, should have been based on the Provider's billed amount of $990.00.

The additional reimbursement of $693.42 is warranted per the Official Medical Fee Schedule code E1399 Modifier LL.

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

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
E1399	LL	3	$693.42	$990.00	$296.58	$693.42	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 E1399 Modifier LL ($693.42) for a total of $1,028.42.

The Claims Administrator *is required to reimburse the provider $1,028.42 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,

[redacted], RHIT
Chief Coding Reviewer

Copy to:
[redacted]

[redacted]