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 29, 2014

[redacted]

IBR Case Number:	CB14-0001071	**Date of Injury:**	07/08/2013
Claim Number:	[redacted]	**Application Received:**	08/01/2014
Claims Administrator:	[redacted]		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	Revenue code 274 (L1832)		

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.

IBR Assignment Date: 10/29/2014

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $250.00 for the review cost and $628.76 in additional reimbursement for a total of $878.76.A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $878.76 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. 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]
Chief Coding Reviewer

cc: [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
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Inpatient Hospital Fee Schedule

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 disputed the denial of an orthotic device billed under rev code 274 (L1832) under DRG 494.
- Based on review of CCR §9789.22, "(7). The cost of durable medical equipment provided for use at home is exempt from this Inpatient Hospital Fee Schedule. The cost of durable medical equipment shall be paid pursuant to Section 9789.60;"
- Section 9789.60 sets the maximum reimbursement fee for DME at 120% of the rate CMS sets for California.
- Provider is requesting reimbursement of $628.76, less than the allowable.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of Revenue code 274 (L1832) is warranted.

Date of Service: 07/14/2013						
Inpatient Hospital Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
L1832	$ 628.76	$ 0.00	$ 628.76	N/A	$628.76	**DISPUTED SERVICE**: See analysis.

Copy to:

[redacted]

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