

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 8, 2015

[Redacted]
[Redacted]
[Redacted]

| | | | |
|------------------------------|--------------|------------------------------|------------|
| IBR Case Number: | CB14-0001530 | Date of Injury: | 07/26/1990 |
| Claim Number: | [Redacted] | Application Received: | 10/13/2014 |
| Claims Administrator: | [Redacted] | Assignment Date: | 11/10/2014 |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | L0635 | | |

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: 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 \$735.37 in additional reimbursement for a total of \$985.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$985.00 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]
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

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 seeking full remuneration for L0635 Orthotic Device issued to Injured Worker during DRG 460 Surgical Services 12/09/2013 – 12/13/2013.**
- Claims Administrator Reimbursement Ration for L0635: “Reimbursement based on ration, percentage or formula set by state guidelines.”
- **HCPCS L0635:** Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment.
- Rev Code 460 Formula as follows: $3.8783 \text{ (Wt. DRG 460)} \times 9492.84 \text{ (Hosp. Conv.)} \times 1.20 \text{ (WC Multi.)} = \$44,179.30$
- **§9789.60** Hospital Inpatient Service: 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.
- Claims Administrator included separately reimbursable L0635 device into the overall payment for DRG 460.
- L0635 device is separately reimbursable.
- **§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).
- Proof of Paid Cost submitted by Provider for (L0635): \$612.81
- OMFS allowance for the HCPCS code L0635 is \$1,114.20.
- 120% Allowance of the documented paid cost is \$735.37

- Based on the aforementioned guidelines and documentation, reimbursement for billed orthotic (L0635) is 120% of the documented paid cost.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code L0635 is warranted.

| Date of Service: 12/09/2013 – 12/13/2013 | | | | | | |
|---|------------------------|---------------------|-----------------------|--------------|-----------------------------------|--------------------------|
| DMEPOS | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Workers' Comp Allowed Amt. | Notes |
| L0635 | \$3,672.06 | \$ 0.00 | \$ 1,114.20 | 1 | \$735.37 | Refer to Analysis |
| DRG 460 | \$ N/A | \$ N/A | \$ N/A | N/A | N/A | Service not in dispute |

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