

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 9, 2015

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001559	Date of Injury:	09/15/2009
Claim Number:	[Redacted]	Application Received:	10/17/2014
Claims Administrator:	[Redacted]	Assignment Date:	11/10/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	E0748		

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 \$3355.04 in additional reimbursement for a total of \$3605.04. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$3605.04 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
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: Durable Medical Equipment, Prosthetics, Orthotics, 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:**
- Claims Administrator reimbursed \$1700.00 and indicated on the Explanation of Review “Recommendation is based on attached invoice.”
- 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. Effective for services rendered on or after July 1, 2013, the maximum reasonable fees for Durable Medical Equipment, Prosthetics, Orthotics, Supplies shall not exceed 120% of the applicable California fees set forth in the Medicare calendar year 2013 “Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule” revised for July 2013”
- Provider dispensed an Orthofix Cervical Stimulator which is documented as DME code E0478.
- Based on information reviewed, additional reimbursement is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code E0478 is recommended.

Date of Service: 7/29/2013							
Durable Medical Equipment							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
E0478	\$5826.10	\$1700.00	\$3406.60	1	N/A	\$5055.04	DISPUTED SERVICE: Allow additional reimbursement \$3355.04

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