

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 24, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0000494	Date of Injury:	09/13/2013
Claim Number:	[REDACTED]	Application Received:	04/03/2015
Assignment Date:	04/30/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/03/2014 – 11/03/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	L3670		

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 \$195.00 for the review cost and \$150.00 in additional reimbursement for a total of \$345.00. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$345.00 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,

Paul Manchester, M.D., M.P.H.  
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
- Medicare DME Classification Payment System
- 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 L3670 Shoulder Orthotic Device issued to Injured Worker on 11/03/2014 during Hospital Outpatient Service.**
- Claims Administrator denied reimbursement based on bundled service rational.
- **§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.
- L3670 device is separately reimbursable.
- UB-04 Reflects \$150.00 Billed for L3670.
- Contractual Agreement Not Available for IBR.
- **§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 not submitted by Provider
- Based on the aforementioned guidelines and documentation, reimbursement is warranted for L3670.

The table below describes the pertinent claim line information.

### DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code L3670

Date of Service: 11/03/2014 DMEPOS						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
L3670	\$150.00	\$ 0.00	\$ 150.00	1	\$150.00	Refer to Analysis

Copy to:

[REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED]

Copy to:

[REDACTED]  
 [REDACTED]  
 [REDACTED]