MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Sacramento, CA 95813-8006
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MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 7, 2015

[redacted]

IBR Case Number:	CB15-0000884	Date of Injury:	11/25/2009
Claim Number:	[redacted]	Application Received:	06/01/2015
Assignment Date:	06/30/2015		
Claims Administrator:	[redacted]		
Date(s) of service:	03/24/2015 – 03/24/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	E1339-LL		

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 $1829.33 in additional reimbursement for a total of $2,024.33. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$2,024.33** 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]

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
- 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: Provider seeking full remuneration for E1399 –LL Durable Medical Equipment Unlisted Code dispensed to Injured Worker for use at home; date of service 03/24/2015.**
- Claims Administrator reimbursed the Provider for E0745 Neuromuscular –stim..
- E1399 Is an Unlisted Durable Medical Equipment Code. The code reflected in the documentation represents an H-wave muscle stimulator unit which differs from the E0745 nerve stimulator (Tens) assigned by the Claims Administrator.
- §9789.60. Durable Medical Equipment, Prosthetics, Orthotics, Supplies. (a) For services, equipment, or goods provided after January 1, 2004, the maximum reasonable reimbursement for durable medical equipment, supplies and materials, orthotics, prosthetics, and miscellaneous supplies and services shall not exceed one hundred twenty (120) percent of the rate set forth in the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule, as established by Section 1834 of the Social Security Act (42 U.S.C. § 1395m) and applicable to California.
- Title 8, §9789.19 For services rendered on or after 4/1/2014, use: the OMFS Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Fee Schedule applicable to the date of service
- H-wave unit has not yet been assigned a DMEPOS code. As such, the Provider may be reimbursed a percentage of the billed Usual and Customary Charge under the OMFS or an existing Contractual Agreement.

- Provider's Usual and Customary fee indicated on CMS 1500 is $3,300.00
- Invoice Reflects $3,300.00 delivered to Injured Worker's Home Address.
- Contractual Agreement reflects 85% OMFS of billed charges.
- Based on the documentation and guidelines, additional reimbursement is warranted for E1399-LL.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: E1399-LL

Date of Service 03/24/2015							
DEMPOS							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
E1399-LL	$3,300.00	$333.50	$2,324.93	N/A	1	$2,805.00	**PPO Contract – Reimbursed Amount = $1,829.33 Due Provider**

Copy to:

[redacted]

Copy to:

[redacted]