

**MAXIMUS FEDERAL SERVICES, INC.**

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

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**Independent Bill Review Final Determination Reversed**

2/28/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 1/18/2013 – 1/18/2013  
MAXIMUS IBR Case: CB13-0000112

Dear [REDACTED]

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/25/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$25.24, for a total of \$360.24.**

**Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:**

The following evidence was used to support the decision:

- 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 or negotiated contract: OMFS
- Other: Official Medical Fee Schedule Information and Instructions, DMEPOS Fee Schedule

**Supporting Analysis:**

The dispute regards the amount paid for an electric heat pad (E0215). The Claims Administrator reimbursed \$36.76 for the billed HCPCS E0215 with the explanation “Payment based on the documented actual cost.”

E0215 – Electric heat pad, moist

Per the Official Medical Fee Schedule General Information and Instructions, for separately reimbursable services, equipment, or goods provided after January 1, 2004, the maximum reasonable reimbursement for durable medical equipment, supplies and materials, orthotics, prosthetics shall not exceed 120% of the rate set forth in the CMS’ Durable Medical Equipment, Prosthetics/Orthotics, and supplies (DMEPOS) Fee Schedule.

The Provider provided the Moist Heat Pad Electric – Custom Touch (E0215) to the worker in the office. The durable medical equipment billed as HCPCS E0215 is listed on the CMS DMEPOS fee schedule and does not require a prescription. The electric heat pad (E0215) is not considered a “Dangerous Device”. The OMFS allowance for covered supplies and equipment listed on the CMS DMEPOS fee schedule not requiring a prescription is based on 120% of the applicable California fees set forth in the Medicare calendar year 2012 “Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule.

MAXIMUS requested a copy of the PPO contract. The PPO contract was not received. The recommended allowances and/or reimbursement amounts were calculated based on the Official Medical Fee Schedule Durable Medical Equipment, Prosthetics, Orthotics, Supplies Effective for Services Rendered on or after January 1, 2013.

The additional reimbursement of \$25.24 is warranted per the Official Medical Fee Schedule code E0215.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
E0215	NU	1	\$23.31	\$62.00	\$36.76	\$25.24	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for HCPCS code E0215 Modifier NU (\$25.24) for a total of \$360.24.

***The Claims Administrator is required to reimburse the provider \$360.24 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers’ Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).***

Sincerely,

[REDACTED], RHIT

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

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[REDACTED]  
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