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

Independent Bill Review Final Determination Reversed

6/19/2014

[redacted]

IBR Case Number:	CB14-0000027	Date of Injury:	2/28/2012
Claim Number:	[redacted]	Application Received:	1/7/2014
Claims Administrator:	[redacted]		
Date(s) of service:	9/6/2013 – 9/6/2013		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	E1399 LL		

Dear [redacted]

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 1/31/2014, 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 $693.42, for a total of $1,028.42.**

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: CMS' Durable Medical Equipment, Prosthetics/Orthotics, and supplies (DMEPOS) Fee Schedule

Supporting Analysis:
The dispute regards the amount paid for Durable Medical Equipment (E1399 Modifier LL). The Provider was reimbursed $296.58 and is requesting additional reimbursement of $693.42. The Claims Administrator based its reimbursement of E1399 on E0745 with the explanation "Based on available information. The bill was reviewed using the Official Medical Fee Schedule of CA."

E1399 - Durable Medical Equipment, miscellaneous
Modifier LL - Lease/rental (use the LL modifier when DME equipment rental is to be applied against the purchase price)

The Provider is the manufacturer of the supplied Durable Medical Equipment (H-Wave Home Device). The original bill submitted with the documentation indicated a billing for 3 units of the billed HCPCS code E1399 Modifier LL. The documentation included a prescription for the H-wave Home Care system. The prescription was from the Primary Treating physician on a report titled "Primary Treating Physician's Progress Report Addendum." The Treatment plan indicated "EWL H-Wave Home Care system for 3 months."

The DME equipment was billed using the HCPCS E1399. The HCPCS code E1399 is not listed on the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and supplies (DMEPOS) Fee Schedule. The cost of the item was documented on the invoice at $3,300.00. A written appeal was submitted with the documentation, the appeal indicated a monthly charge of $330.00 and billed amount of $990.00 for 3 months rental charge for the H-Wave unit. The Claims Administrator did not indicate on the explanation of review (EOR) a pre-negotiated fee arrangement of $296.58 or allowance of E0745. Therefore, the reimbursement of H-Wave unit billed using HCPCS E1399 Modifier LL, should have been based on the Provider's billed amount of $990.00 for 3 months.

The additional reimbursement of $693.42 is warranted per the Official Medical Fee Schedule code E1399 Modifier LL.

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
E1399	LL	3	$693.42	$990.00	$296.58	$693.42	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 E1399 Modifier LL ($693.42) for a total of $1,028.42.

The Claims Administrator *is required to reimburse the provider $1,028.42 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]

Copy to:

[redacted]