

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

7/18/2014

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

IBR Case Number:	CB14-0000033	Date of Injury:	11/15/2001
Claim Number:	[REDACTED]	Application Received:	1/9/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	1/3/2014 – 1/3/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	L0635		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/24/2014, 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 \$735.37, for a total of \$1,070.37.**

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 (OMFS) or negotiated contract: OMFS
- Other: OMFS Inpatient Hospital Fee Schedule

Supporting Analysis:

The dispute regards the denial of an orthotic device (L0635) billed as part of inpatient hospital services (DRG 455). The Claims Administrator reimbursed the Provider \$74,492.99 on the initial explanation of review and denied any additional allowance on the final explanation of review with the following explanation "The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted."

The Provider is disputing the denial of additional allowance for the Spinal Orthotic device (L0635).

- **HCPCS L0635:** Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment.

Per the Official Medical Fee Schedule (OMFS) Inpatient Services, 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. The HCPCS L0635 is a type of Orthotic and are reimbursable when billed by a Hospital under the OMFS DMEPOS fee schedule per Title 8, CCR, section 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). The Provider submitted an invoice indicating the documented paid cost of the Spinal Orthotic (L0635) was \$612.81. The OMFS allowance for the HCPCS code L0635 is \$1,337.04. The allowance of 120% of the documented paid cost is less than the OMFS allowance; therefore, the recommended reimbursement for the billed orthotic (L0635) is 120% of the documented paid cost.

Per a review of the explanation of review (EOR), the Claims Administrator reimbursed the Provider for the billed inpatient services (DRG 455) based on the OMFS Inpatient Hospital Fee Schedule. However, the reimbursement did not include an allowance for the billed orthotic HCPCS L0635; therefore, additional reimbursement is warranted for the HCPCS L0635.

The reimbursement of \$735.37 is warranted per the OMFS Inpatient Hospital Services (L0635).

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
L0635	1	\$674.09	\$735.37	\$0.00	\$735.37	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 L0635 (\$735.37) for a total of \$1,070.37.

The Claims Administrator is required to reimburse the provider \$1,070.37 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]

Copy to:

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