

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280

Independent Bill Review Final Determination Reversed

10/7/2014

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|-----------------------|-----------------------|-----------------------|------------|
| IBR Case Number: | CB14-0000321 | Date of Injury: | 11/04/2012 |
| Claim Number: | ██████████ | Application Received: | 03/06/2014 |
| Claims Administrator: | ████████████████████. | | |
| Date(s) of service: | 11/10/2013 | | |
| Provider Name: | ████████████████████ | | |
| Employee Name: | ██████████ | | |
| Disputed Codes: | E1399-LL | | |

Dear ██████████:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 04/23/2014, 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 \$500.82, for a total of \$835.82.**

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

Analysis and Findings:

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider dissatisfied with reimbursement of code E1399-LL.**
- The Provider is the manufacturer of the supplied Durable Medical Equipment (H-Wave Home Device).
- The DME equipment was billed using the HCPCS code E1399
- HCPCS code E1399 is not listed on the CMS’ Durable Equipment, Prosthetics/Orthotics and Supplies (DMEPOS) Fee Schedule.
- The cost of the item was documented on the Manufacturers Invoice at \$3300.00.
- A written appeal was submitted with the documentation, the appeal indicated a three month charge of \$990.00 and purchase price of \$3300.00
- The original bill submitted with the documentation indicated a billing for three (3) units of the billed HCPCS code E1399 Modifier LL.
- The documentation included: denied utilization review, approved authorization for 3 additional months of home H-wave, Manufacturers Invoice, Primary Treating Physician’s Progress Report Addendum.
- Utilization Review first denied 3 months rental of H-Wave unit on 11/18/2013 then reversed on 11/26/2013 approving 3 month rental.
- Claims Administrator did not indicate on the explanation of review (EOR) or authorization, a pre-negotiated fee arrangement or allowance of E0745.
- EOR states “Any reduction is in accordance with the PPO contract.”
- Claims Administrator does indicate on the explanation of review (EOR) a PPO Savings.
- Provider contract states 25% off Usual and Customary.
- **DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of \$500.82 to be made to the Provider.**

| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Workers’ Comp Allowed Amount | Notes |
|---|-----------------|--------------|----------------|----------|------------------------------|---|
| <i>Date of Service – 11/10/2013</i> <i>Durable Medical Equipment</i> | | | | | | |
| E1399-LL | \$990.00 | \$241.68 | \$748.32 | 3 months | \$742.50 | DISPUTED SERVICE – Additional reimbursement to the provider to be made for \$500.82. |

Determination: Reversed

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 CPT code E1399 Modifier LL (\$500.82) for a total of \$835.82.

*The Claims Administrator is required to reimburse the provider \$835.82 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
Chief Coding Reviewer

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[REDACTED] **[REDACTED]**
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