**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**

10/8/2014

[redacted]

| | | | |
|---|---|---|---|
| IBR Case Number: | CB14-0000365 | Date of Injury: | 05/28/2013 |
| Claim Number: | [redacted] | Application Received: | 03/13/2014 |
| Claims Administrator: | [redacted] | | |
| Date(s) of service: | 10/26/2013 | | |
| Provider Name: | [redacted] | | |
| Employee Name: | [redacted] | | |
| Disputed Codes: | E1399 LL | | |

Dear Electronic Waveform Lab:

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 05/05/2014, 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

**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 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 purchase price of $3,300.00.
- 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 a prescription for the H-wave Home Care system. The documentation included a report titled "Primary Treating Physician's Progress Report Addendum", which indicated the following Treatment Plan and Prescription: "Continued current treatment plan with the EWL H-Wave Homecare System for: 3 Months."
- Utilization Review approved request for a three (3) month rental of H-Wave unit.
- Reimbursement of H-Wave unit billed using HCPCS E1399 Modifier LL, should have been based on the Provider's billed amount of $990.00.
- **DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of $693.42 to be made.**

| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Workers' Comp Allowed Amount | Notes |
|---|---|---|---|---|---|---|
| ***Date of Service – 10/26/2013 Durable Medical Equipment*** | | | | | | |
| **E1399 – LL** | **$990.00** | **$296.58** | **$693.42** | **3** | **$990.00** | **DISPUTED SERVICE – Additional reimbursement to the provider to be made for $693.42** |

**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 ($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
Chief Coding Reviewer

Copy to:
[redacted]

Copy to:
[redacted]