

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 15, 2014

[Redacted]

IBR Case Number:	CB14-0000870	Date of Injury:	03/04/2013
Claim Number:	[Redacted]	Application Received:	06/16/2014
Claims Administrator:	[Redacted]	Assignment Date:	09/11/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	E1399-LL		

Dear [Redacted]

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

[Redacted]

cc: [Redacted]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- 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
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

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

- **ISSUE IN DISPUTE:** Provider is dissatisfied with reimbursement of E1399-LL, for the H-Wave Device.
- Claims Administrator reimbursed \$808.80 and indicated on the Explanation of Review “The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service.”
- Provider states on the IBR application under Reason for Disputing Reduction or Denial of Full Payment: “Usual and Customary, Authorized”
- Documentation submitted includes the Primary Treating Physician’s Progress Report Addendum which requests the purchase/indefinite use for the H Wave device. Provider documents Rationale for Medical Necessity of the H Wave Device, however, nowhere on the request does it state which DME code will be billed or the charge for this device.
- A separate document submitted for this review shows the Provider’s rental and purchase charges for the H Wave device along with the billing code E1399. It is not evident that the document containing the Provider’s charges and billed code was received by the Claims Administrator’s Utilization Review as part of their review for approved authorization of the H Wave device.
- Authorization letter received approves “Purchase of Home H-wave device for home use”
- Claims Administrator based their reimbursement on DME code E0745 which is a comparable code to the E1399 and was correct in doing so.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of code E1399 is not warranted.

Date of Service: 1/22/2014						
Durable Medical Equipment						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
E1399-LL	\$2970.00	\$808.80	\$2161.20	1	\$0.00	DISPUTED SERVICE: No reimbursement recommended

Copy to:

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[REDACTED]
[REDACTED]
[REDACTED]

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[REDACTED]
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