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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 27, 2015

[redacted]

IBR Case Number:	CB14-0001728	**Date of Injury:**	10/12/2013
Claim Number:	[redacted]	**Application Received:**	11/17/2014
Claims Administrator:	[redacted]	**Assignment Date:**	12/29/2014
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: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $250.00 for the review cost and $2,343.00 in additional reimbursement for a total of $2,593.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $2,593.00 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. 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,

Paul Manchester, M.D., M.P.H.
Medical Director

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
- 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 seeking full remuneration E1399 –LL Durable Medical Equipment Unlisted Code dispensed to Injured Worker for use at home; date of service 04/07/2014.**
- Claims Administrator reimbursed the Provider for E0730 NU indicating: "Recommendation of payment has been based on this procedure code, E0730, which best describes services rendered."
- **E1399** Is an Unlisted Durable Medical Equipment Code. The code reflected in the documentation represents an H-wave muscle stimulator unit which differs from the E0730 nerve stimulator (Tens) assigned by the Claims Administrator.
- **Modifier, LL** reflected on the CMS 1500 form indicates rental price applied to purchase.
- **§9789.60.** Durable Medical Equipment, Prosthetics, Orthotics, Supplies. (a) For services, equipment, or goods provided after January 1, 2004, the maximum reasonable reimbursement for durable medical equipment, supplies and materials, orthotics, prosthetics, and miscellaneous supplies and services shall not exceed one hundred twenty (120) percent of the rate set forth in the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule, as established by Section 1834 of the Social Security Act (42 U.S.C. § 1395m) and applicable to California.

- **Title 8, §9789.19** For services rendered on or after 4/1/2014, use: the OMFS Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Fee Schedule applicable to the date of service
- H-wave unit has not yet been assigned a DMEPOS code. As such, the Provider may be reimbursed a percentage of the billed Usual and Customary Charge under the OMFS or an existing Contractual Agreement.
- Provider is the Manufacturer of the H-wave Unit E1399.
- Provider's Usual and Customary fee indicated on invoice is $3,300.00
- Invoice Reflects $3,300.00 E1399 Unit delivered to Injured Worker's Home Address.
- Contractual Agreement reflects 80% OMFS of billed charges.
- Modifier – LL dictates previous rental/lease payment to be applied to purchase.
- Documentation indicates E1399-LL unit utilized as $231.00 rental on 03/04/2014 prior to authorized purchase of same unit on 04/07/2014.
- Based on the documentation and guidelines, additional reimbursement is warranted for E1399-LL.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code E1399-LL is warranted.

Date of Service: 04/07/2014							
DEMPOS							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
E1399-LL	$3,399.00	$66.00	$3,332.17	N/A	1	$2,343.00	**PPO Contract – Reimbursed Amount – Rental Payment = $2,640.00 Due Provider**

Copy to:

[redacted]

Copy to:

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