

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

February 24, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-0001789	Date of Injury:	02/21/1978
Claim Number:	[REDACTED]	Application Received:	11/21/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	12/24/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	L5969		

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 \$15,963.35 in additional reimbursement for a total of \$16,213.35. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$16,213.35 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, MD, MPH  
Medical Director

cc: [REDACTED]  
[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: **8 CCR §9789.60. (2)**

## 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 L5969, Bio T2 Foot (11-00A)
- Claims administrator reimbursed \$16,056.65 indicating on the Explanation of Review “Approved by Utilization Review”
- Notice of Authorization dated September 5, 2014 states “This letter will confirm that the treatment recommendation outlined by you is authorized. Below please find the specific outline of that authorization to include description to include frequency, duration and quantity if applicable: DME: Right BK prosthesis and supplies”
- The maximum reasonable fee for DME (except for a “dangerous device”) is capped at the rate in the workers’ compensation [DMEPOS fee schedule](#) established pursuant to [Labor Code section 5307.1](#), and title 8, California Code of Regulations section 9789.60. The

workers' compensation DMEPOS maximum is 120% of the Medicare DMEPOS rate for California. (DWC)

- **ARTICLE 2. Definitions [4015 - 4046]** ( *Article 2 added by Stats. 1996, Ch. 890, Sec. 3.*) **4022.** “Dangerous drug” or “dangerous device” means any drug or device unsafe for self-use in humans or animals, and includes the following:
  - Any drug that bears the legend: “Caution: federal law prohibits dispensing without prescription,” “Rx only,” or words of similar import.
  - Any device that bears the statement: “Caution: federal law restricts this device to sale by or on the order of a \_\_\_\_\_,” “Rx only,” or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.
  - Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.(*Amended by Stats. 2003, Ch. 250, Sec. 1. Effective January 1, 2004.*)
- **Labor Code §5307.1** subdivision (e)(4) provides that the fee is the **lesser** of the DMEPOS allowed amount or an amount calculated by applying a formula to the documented paid cost:
  - For a dangerous device dispensed by a physician, the reimbursement to the physician shall not exceed either of the following:
    - (a) The amount allowed for the device pursuant to the official medical fee schedule adopted by the administrative director.
    - (b) One hundred twenty percent of the documented paid cost, but not less than 100 percent of the documented paid cost plus the minimum dispensing fee allowed for dispensing prescription drugs pursuant to the official medical fee schedule adopted by the administrative director, and not more than 100 percent of the documented paid cost plus two hundred fifty dollars (\$250).
- **8 CCR §9789.60. (2)** Dispensed durable medical equipment: cost (purchase price plus sales tax plus shipping and handling) plus 50% of cost up to a maximum of cost plus \$25.00 not to exceed the provider’s usual and customary charge for the item.
- Invoice from Vendor to Provider reflects “list price” of “\$32,000.00” with a “unit price” of “\$32,000.00,” for 11-00A.
- Invoice from Vendor to Provider reflects “Sale Amount” and “Balance Due” amount of “\$32,000.00,” for 11-00A.
- Invoice from Vendor to Provider reflects Freight charge for 11-00A as \$20.00.
- Cost + \$20.00 = \$32,020.00.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code L5969 is recommended

<b>Date of Service:</b> 7/31/2014							
<b>Durable Medical Equipment</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
L5969	\$38,000.00	\$16,056.65	\$21,943.35	1	N/A	\$32,020.00	<b>DISPUTED SERVICE:</b> Allow reimbursement \$15,963.35

Copy to:

[REDACTED]

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[REDACTED]