

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



## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 29, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0000156	Date of Injury:	02/24/2014
Claim Number:	[REDACTED]	Application Received:	02/02/2015
Claims Administrator:	[REDACTED]		
Date Assigned:	2/26/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	E1339-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 \$195.00 for the review cost and \$495.00 in additional reimbursement for a total of \$690.00. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$690.00 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]  
[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 is dissatisfied with denial of E1399 –LL Durable Medical Equipment Unlisted Code dispensed to Injured Worker for use at home; date of service 10/20/2014.**
- Claims Administrator denied E1399 LL indicating on the Explanation of Review: “This service requires prior authorization and none was identified.”
- Documentation received for this review included RFA which requested: Continue H-Wave x 2 months.
- A Notice of Authorization dated 07/02/2014 from Claims Utilization Review was also received stating: Treatment/services requested: 1. H-wave rental x 2 months for the right thumb; 2. Occupational therapy 2 times per week for 6 weeks for the right thumb. **Decision: This request has been authorized.**
- **E1399** Is an Unlisted Durable Medical Equipment Code. The code reflected in the documentation represents an H-wave muscle stimulator unit.
- **§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 was received showing \$330.00 for a 1 month rental charge along with billing code to be used E1399 for the H-wave unit.
- Contractual Agreement reflects 75% of Usual and Customary charges.
- Modifier – LL dictates previous rental/lease payment to be applied to purchase.
- Based on the documentation and guidelines, additional reimbursement is warranted for E1399

The table below describes the pertinent claim line information.

Date of Service 10/20/2014							
DEMPOS							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
E1399-LL	\$660.00	\$0.00	\$660.00	N/A	1	\$495.00	<b>Allow reimbursement \$495.00</b>

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