

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 15, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0002308	Date of Injury:	03/29/20102
Claim Number:	[REDACTED]	Application Received:	11/03/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/02/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	L0627		

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 \$391.50 in additional reimbursement for a total of \$586.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$586.50** 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
- CMS DME – CA
- OMFS

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 remuneration for L0627 Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from l-1 to below l-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise, for date of service 12/02/2014.**
- The Claims Administrator denied service with the following rationale: “In order to review this charge, we will need a copy of the invoice”
- PPO Contractual Agreement regarding DME reimbursement not submitted for IBR; unable to verify if the document paid cost for DME is a requirement.
- Provider states dispensed DME is pursuant to **LC 5307.1 (e)(4)(b)** refers to “dangerous device.”
- **Business and Professional California Code 4022.** “Dangerous drug” or “dangerous device” means any drug or device unsafe for self-use in humans or animals, and includes the following :**(a)** Any drug that bears the legend: “Caution: federal law prohibits dispensing without prescription,” “Rx only,” or words of similar import. **(b)** 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.**(c)** Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

- There is no indication that the dispensed LSO (lumbosacral orthosis) required a prescription.
- **§ 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.
- Opportunity for Claims Administrator to Dispute Eligibility sent on 12/22/2015. A response from Claims Administrator was not received for this review.
- **In the absence of the full contractual agreement defining reimbursement for DMEPOS, or information identifying the dispensed L0627 as a dangerous device as defined by LC 5307.1 (e)(4)(b), reimbursement is indicated pursuant to § 9789.60.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: L0627

Date of Service: 12/02/2014						
DMEPOS						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
L0627	\$391.50	\$0.00	\$391.50	1	\$391.50	Refer to Analysis

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