

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 16, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001116	Date of Injury:	09/29/2013
Claim Number:	[Redacted]	Application Received:	08/11/2014
Claims Administrator:	[Redacted]	Assignment Date:	09/19/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	95951 (x 3)		

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]
[Redacted]

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: OMFS Physician Fee Schedule, General Information and Instructions -By Report

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 CPT 95951 x3.
- Claims Administrator reimbursed \$1124.49 indicating on the Explanation of Review “The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.”
- Provider billed CPT 95951 - Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours. Provider billed for 3 units, 72 hours. 95951 has a status code ‘C’ – If payable, these codes will be paid “By Report”, generally following review of documentation such as an operative report.
- **PROCEDURES WITHOUT UNIT VALUES (“BY REPORT”)** Unit values are not shown for some procedures listed in the Schedule. Fees for such procedures need to be justified by report, although a detailed clinical record is not necessary. By Report (BR): Procedures coded BR (By Report) are services which are unusual or variable. An unlisted service or one that is rarely provided, unusual or variable may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are: complexity of symptoms; final diagnosis;

pertinent physical findings; diagnostic and therapeutic procedures; concurrent problems; follow-up care. In some instances, the values of BR procedures may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc., as required for the procedure performed.

- A one page Video Ambulatory Electroencephalography Report was submitted by Provider.
- Approved authorization for a 72 hour video EEG ambulatory was received stating “Services will be paid pursuant to the Official Medical Fee Schedule or an appropriate PPO contract.” Authorization does not agree on any Usual and Customary fee Provider might have, nor was the request for authorization submitted for this review to document if a fee was requested.
- Based on information reviewed, additional reimbursement is not warranted for CPT 95951.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code

Date of Service: 1/17/2014 – 1/20/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
95951 x 3	\$7800.00	\$1124.49	\$6675.51	N/A	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended

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