

---

## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 2, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001311	Date of Injury:	12/28/2010
Claim Number:	[REDACTED]	Application Received:	08/10/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/02/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99204 and 95913		

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,

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: CPT Assistant

## 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 95913 and denial of 99204.
- Claims Administrator down coded 95913 to 95912
- Guidelines: The section for nerve conduction tests was restructured with new codes (95907-95913) to further describe the reporting based on the number of studies performed. The new guidelines define a single conduction study as follows: For the purposes of coding, a single conduction study is defined as a sensory conduction test, a motor conduction test with or without an F wave test, or an H-reflex test. Each type of study (sensory, motor with or without F wave, H-reflex) for each nerve includes all orthodromic and antidromic impulses associated with that nerve, and constitutes a distinct study when determining the number of studies in each grouping (eg, 1-2 or 3-4 nerve conduction studies). **Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded.** The numbers of these separate tests should be added to determine which code to use. (CP T 2013, p 535)
- Provider documents Left Median and Left Radial Digit 1 more than once and should only be counted once.
- Reimbursement of 95913 is not warranted.
- Provider billed code 99204-25 on CMS 1500 showing the Referring Provider in box #17.
- Authorization for an E&M or consultation was not identified in this review.

- As Provider is not the Primary Treating Physician, authorization is needed for reimbursement.
- Authorization for Referring Provider received shows EMG/NCV to left upper extremity, certified per peer review report.
- Based on aforementioned and guidelines, reimbursement of 99204 is not warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99204 and 95913**

<b>Date of Service: 02/02/2015</b>						
<b>Physician Services</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99204	\$354.10	\$0.00	\$191.11	1	\$0.00	<b>DISPUTED SERVICE:</b> Reimbursement not recommended
95912	\$686.90	\$312.99	\$48.91	1	\$312.99	<b>DISPUTED SERVICE:</b> Reimbursement not recommended

Copy to:

[REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED]

Copy to:

[REDACTED]  
 [REDACTED]  
 [REDACTED]