

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 22, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001442	Date of Injury:	08/27/2012
Claim Number:	[REDACTED]	Application Received:	08/24/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/22/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99204-25 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: 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 \$27.76 in additional reimbursement for a total of \$222.76. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$222.76 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: 15% PPO Discount
- National Correct Coding Initiatives

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 code 99204-25 and reimbursement of 95913.
- Claims Administrator denied code 99204-25 indicating on the Explanation of Review “The value of this procedure is included in the value of another procedure performed on this date”
- Modifier -25: Significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure or other service.
- Provider’s report submitted does not document a significant and separate identifiable E/M service as abstracted from report shows a Patient Complaint, Exam, Electrodiagnostic Study, NCV & EMG Findings and Impression of testing on the bilateral extremities.
- Reimbursement of 99204-25 is not warranted.
- Provider billed code 95913 which Claims Administrator down coded to 95911: Nerve conduction studies; 9-10 studies
- Per CPT Assistant, AMA on Nerve Conduction Studies: 95907-95913 describe one or more nerve conduction studies performed, rather than having each nerve as the unit of service.
- 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-relex test. Each type of study (sensory, motor with or without F wave, H-relex) 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.

- Motor Summary Table shows multiple studies performed on the ulnar motor nerve which should only be counted as ‘1’ on each extremity.
- Based on aforementioned guidelines and documentation reviewed, reimbursement of 95912 is warranted.
- EOR reflects a 15% PPO discount to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99204-25 and 95913

Date of Service: 10/22/2014						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
95912	\$686.90	\$250.29	\$111.61	1	\$278.05	DISPUTED SERVICE: Allow reimbursement \$27.76

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