

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 28, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001447	Date of Injury:	01/14/2014
Claim Number:	[REDACTED]	Application Received:	08/25/2015
Assignment Date:	09/14/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/30/2015 – 04/30/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	95913 and 95937		

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 \$142.17 in additional reimbursement for a total of \$337.17. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$337.17** 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
- 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 95913 Nerve conduction studies; 13 or more studies and 95937 Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method, performed on 04/30/2015.**
- The Claims Administrator based reimbursement for CPT 95913 on 95912 Nerve conduction studies; 11-12 studies with the following rational: “Per CPT guidelines, nerve conduction studies are paid per nerve, not per site along the same nerve.”
- EOR’s Reflect 85% OMFS
- CMS 1500 indicates the following diagnoses for 95913 1) 780.79 Malaise and Fatigue, 2) 782.0 Skin sensation disturbance, & 3) 724.1 Pain in thoracic spine.
- CPT Appendix J indicates for diagnosing “Pain, Numbness, or Tingling (bilateral)”, the maximum number of studies to be performed is four (4) motor nerves with or without F-wave, six (6) sensory nerves and 2 H-reflexes. The appropriate number of NCVs for reimbursement is **12**.
- 04/23/2015 Authorization reflects **services requested by a PQME** as evidence in a contested claim.
- 03/19/2015 request from Legal Parties states the PQME (referring Provider) has the “authority to perform any diagnostic testing needed in order to make (a) determination on this claim.”
- 04/23/2015 Authorization from PQME to Provider indicates request for “EMG/NCV and Neurodiagnostic testing/Consult.”
- **95913** Documentation reflects studies performed on **bilateral** upper entities.
- **95937** Denied by Claims Administrator with the following rational: “The Diagnostic Utility of this Procedure has not been established for the patient’s condition. The service appears to be unrelated to the Patients’ Diagnosis.”
- Documentation reflects services performed as part of evidence regarding a contested claim, fulfilling the request of the referring PQME.
- **Based on the aforementioned documentation and guidelines, reimbursement for 95913 and 95937 is supported.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 95913 & 95937

Date of Service: 04/30/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
95913 & 95937	\$1,006.01	\$278.05	\$278.91	1	\$420.22	PPO Contract – Reimbursed Amount \$142.17 Due Provider

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