
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 25, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001464	Date of Injury:	05/22/2013
Claim Number:	[REDACTED]	Application Received:	08/27/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	03/03/2015		
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: 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: 10% 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 reimbursement of codes 95913 and 95937
- For the purposes of coding, a single conduction study is denied 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.
- Nerve Conduction Studies summary table shows multiple testing on the Tibial and Peroneal nerves, however, should only be counted once on the right and left sides.
- Reimbursement of 95911 was correct by the Claims Administrator. Reimbursement of 95913 is not warranted.
- Provider also billed 95937 which Claims Administrator did reimburse two units. A PPO discount of 10% was applied to reimbursement which Provider is not disputing.
- Reimbursement of \$190.35 was the correct amount paid to Provider and therefore, no further reimbursement is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 95913 and 95937

Date of Service: 03/03/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99213 as 99211	\$686.90	\$265.01	\$96.89	1	\$265.01	See Analysis
95937	\$319.20	\$190.35	\$101.83	2	\$190.35	See Analysis

Copy to:

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