

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

September 30, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

|                       |                 |                       |            |
|-----------------------|-----------------|-----------------------|------------|
| IBR Case Number:      | CB15-0001500    | Date of Injury:       | 05/14/2014 |
| Claim Number:         | [REDACTED]      | Application Received: | 08/31/2015 |
| Claims Administrator: | [REDACTED]      |                       |            |
| Date(s) of service:   | 04/20/2015      |                       |            |
| Provider Name:        | [REDACTED]      |                       |            |
| Employee Name:        | [REDACTED]      |                       |            |
| Disputed Codes:       | 95913 and 95887 |                       |            |

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 \$239.84 in additional reimbursement for a total of \$434.84. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$434.84 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:
- National Correct Coding Initiatives
- Other: CPT Assistant January 2014, Volume 24, Issue 1, page 8

## 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 95887.
- Claims Administrator denied code 95887 indicating on the Explanation of Review “The charge was denied as the report/documentation does not indicate that the service was performed”
- Code 95887 is intended to be used per site tested. Sites recognized are unilateral cervical, thoracic paraspinal muscles, abdominal muscles and lumbar paraspinal muscles.
- Documentation includes dictated evaluation report and computerized results of studies; reflecting 95887: Left and right thoracic paraspinal and left cervical paraspinal
- Reimbursement is warranted for 95887.
- Provider also billed code 95913 which Claims Administrator down coded to 95911.
- Nerve Conduction Studies table shows twelve nerves tested and recorded.
- Reimbursement of 95912 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 95912 and 95887

| <b>Date of Service:</b> 04/20/2015 |                        |                     |                       |              |                                   |   |
|------------------------------------|------------------------|---------------------|-----------------------|--------------|-----------------------------------|---|
| <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>  |
| 95912                              | \$685.90               | \$294.46            | \$67.44               | 1            | \$327.12                          | <b>DISPUTED SERVICE:</b> Allow reimbursement \$32.66  |
| 95887                              | \$360.24               | \$0.00              | \$207.72              | 2            | \$207.18                          | <b>DISPUTED SERVICE:</b> Allow reimbursement \$207.18 |

Copy to:

██████████  
 ████████████████████  
 ████████████████████████████████

Copy to:

██  
 ██  
 ██