

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 1, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000626	Date of Injury:	06/25/2007
Claim Number:	[Redacted]	Application Received:	04/21/2015
Claims Administrator:	[Redacted]		
Date Assigned:	5/16/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99204-25, 95913, 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 \$129.87 in additional reimbursement for a total of \$324.87. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$324.87 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

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 codes 99204-25 and 95887 along with the reimbursement of code 95913
- Claims Administrator denied 99204-25 indicating on the Explanation of Review “The billed procedure does not meet the minimum requirements as listed in the fee schedule”
- Modifier -25 designates a significant separately identifiable evaluation and management service by the same physician on the same day of the procedure or service.
- Provider’s report submitted documents the electrodiagnostic study. Documentation submitted does not support a significant separately identifiable evaluation and management service and therefore, reimbursement is not warranted for 99204.
- Claims Administrator also 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”
- Documentation includes dictated evaluation report and computerized results of studies; both reports reflect service 95887 and therefore, reimbursement is warranted.
- CPT 95913 was reimbursed as 95912 with Claims Administrator indicating “The procedure code billed does not accurately describe the services performed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing”

- Documentation includes dictated evaluation report and computerized results of studies. Both reports reflect service 95913, specifically 14 studies.
- Based on information reviewed, additional reimbursement for 95913 is warranted.
- EOR received 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 code 95887 and 95913

Date of Service: 11/10/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
95913	\$686.90	\$266.04	\$48.91	1	N/A	\$307.62	DISPUTED SERVICE: Allow reimbursement \$41.58
95887	\$180.12	\$0.00	\$103.90	1	N/A	\$88.29	DISPUTED SERVICE: Allow reimbursement \$88.29

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