

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

July 10, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0000796	Date of Injury:	01/08/2013
Claim Number:	[Redacted]	Application Received:	05/18/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	01/19/2015		
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 \$244.57 in additional reimbursement for a total of \$439.57. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$439.57 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 reimbursement of code 95913 and denial of code 95937
- Claims Administrator denied code 95937 indicating on the Explanation of Review “Payment for this service has been denied because it appears to be unrelated to the claimed work illness or injury”
- Request form submitted to Provider from attorney dated December 5, 2014 states the injured worker filed an industrial injury claim for the “Neck, Bilateral Upper Extremities” and “Please perform your usual thorough and complete examination...”
- Provider documented EMG testing and computerized findings in submitted report for date of service 1/19/2015
- Provider’s report submitted documents computerized results of two units for right and left abductor digiti minimi muscle which the Provider felt is necessary to test due to bilateral extremity pain which was requested for him to evaluate.
- Reimbursement is warranted for 95937
- Claims Administrator reimbursed code 95913 as 95912 indicating on the Explanation of Review “Recommendation of payment has been based on a procedure code which best describes services rendered”
- Provider documented testing, evaluation and computerized results for fourteen nerves.

- Based on information reviewed, reimbursement is warranted for 95913.

The table below describes the pertinent claim line information.

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

<b>Date of Service:</b> 1/19/2015							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
95913	\$666.90	\$312.99	\$48.91	1	N/A	\$361.90	<b>DISPUTED SERVICE: Allow reimbursement \$48.91</b>
95937	\$319.20	\$0.00	\$195.06	2	N/A	\$195.06	<b>DISPUTED SERVICE: Allow reimbursement \$195.06</b>

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