

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 7, 2015

[REDACTED]
[REDACTED] [REDACTED] [REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000798	Date of Injury:	09/05/2006
Claim Number:	[REDACTED]	Application Received:	05/18/2015
Assignment Date:	06/17/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	01/22/2015 – 01/22/2015		
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 \$88.29 in additional reimbursement for a total of \$283.29. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$283.29** 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
- Official Medical Fee Schedule

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 CPT code 95887, electromyography, and CPT code 95913, 13 or more Nerve Conduction Studies, for date of 1/22/15, performed on 1/22/15.**
- The Claims Administrator denied the **95887** service with the following rationale: “The charge was denied as the report/documentation does not indicate that the service was performed.”
- Contractual Agreement not yet received for IBR. EOR reflects 85% OMFS and will be utilized in the final determination calculations.
- The AMA CPT manual describes a 95887 service as, “Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude, and latency/velocity study (List separately in addition to code for primary procedure)”.
- The provider submitted CPT code 95887 for the service described in the records as Left and Right Lumbosacral Paraspinal Low Rami” and “Left and Right Thoracic Paraspinal Mid Rami”, which substantiates electromyography of two axial muscle groups done bilaterally on the same date as nerve conduction studies.
- Based on the records submitted and the review of the CPT descriptor, CPT code 95887 is supported and reimbursement is recommended.
- The Claims Administrator adjusted the **95913** service stating, “95913 changed to 95912 better defining services performed. The charge has been adjusted to the scheduled allowance. The documentation doesn’t support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.”
- The provider submitted CPT code 95913, 13 or more Nerve Conduction Studies.
- The documentation for the date of service reflected the testing of six (6) sensory nerves, eight (8) motor nerves and two (2) H-reflexes.

- AMA CPT Appendix J includes a listing of the maximum number of nerves to be tested for each diagnostic category necessary for a physician to arrive at a diagnosis in 90% of the patients with that final diagnosis. AANEM states “the number of nerves tested should be the minimum necessary to address the clinical issue”. In this case, the clinical issue was low and mid back pain radiating to the bilateral lower extremities--worse on the right. The working diagnoses listed by the provider were “pain in limb” and “nerve pain”.
- The table in 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.
- Based upon the documentation and review of AANEM guidelines for NCVs as well as CPT Appendix J, changing CPT code 95913 to 95912 is supported and the reimbursement for CPT code 95912 according to the scheduled allowance is recommended and upheld.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 95887 & 95913

Date of Service: 01/22/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
95887	\$180.12	\$0.00	\$103.86	N/A	1	\$88.29	PPO Contract
95913 as 95912	\$686.90	\$266.04	\$95.86	N/A	1	\$266.04	Uphold Refer to Analysis

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