

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 18, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001163	Date of Injury:	09/15/1997
Claim Number:	[REDACTED]	Application Received:	07/17/2015
Assignment Date:	08/05/52015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/13/2015 – 02/13/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	95970		

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 \$70.61 in additional reimbursement for a total of \$265.61. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$265.61** 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
- NCCI Medicare Billing Manual
- PPO Contract: 85%

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 95970 Electronic analysis of implanted neurostimulator pulse generator system performed on 02/13/2015.**
- The Claims Administrator denied reimbursement stating services “does not normally warrant a charge.”
- NCCI Medicare Billing Manual, Chapter XI, Page 24 (L) Neurology and Neuromuscular Procedures, Revision Date (Medicare): 1/1/2014: If nerve testing (e.g., EMG, nerve conduction velocity) is performed to assess the level of paralysis **during anesthesia or during mechanical ventilation**, the range of CPT codes 95851-95943 are not separately reportable. These codes describe significant, separately identifiable diagnostic services **requiring a formal report in the medical record**. Electrical stimulation used to identify or locate nerves **during a procedure** involving treatment of a cranial or peripheral nerve (e.g., nerve XI-25 block, nerve destruction, neuroplasty, transection, excision, repair) is integral to the procedure and is **not separately reportable**.
- CMS1500 indicates Evaluation and Management service with Modifier – 25. Documentation for date of service 02/13/2015 reflects Injured Worker treated for Medication Management.
- **Anesthesia or mechanical ventilation** service not indicated in reports submitted for IBR.
- **Separate 4 page electronic report** from E&M service reflecting Neruostimulator analysis reviewed.
- PPO Contract reflects 85% OMFS.
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for 95970.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 95970

Date of Service: 02/13/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
95970	\$525.00	\$0.00	\$83.07	1	\$70.61	PPO Contract

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