

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 13, 2016

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

IBR Case Number:	CB16-0000628	Date of Injury:	04/01/2013
Claim Number:	██████████	Application Received:	04/18/2016
Claims Administrator:	██████████		
Date(s) of service:	11/20/2015		
Provider Name:	██████████		
Employee Name:	██████████		
Disputed Codes:	95913 and 95831		

Dear ██████████:

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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: ██████████
██

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: N/A
- 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 seeking remuneration for codes 95913 and 95831 performed on date of service 11/20/2015
- Utilization Review dated October 30, 2015 documents “Certified” PT of the right knee and cervical spine surgical consultation. Authorization does not mention nerve or muscle testing.
- Provider billed codes along with 95861 on a CMS 1500 for date of service 11/20/2015.
- Claims Administrator denied code 95913 with indication “Per NCCI, the procedure code is denied as per the CPT manual or CMS manual coding instructions.”
- Pair code does exist between code 95861, which was reimbursed, and 95913. Modifier Indicator column shows ‘0’
- 95913 is not separately reimbursed and therefore, does not warrant payment.
- CPT 95831: Muscle testing, manual (**separate procedure**) with report; extremity (excluding hand) or trunk
- **CHAPTER I GENERAL CORRECT CODING POLICIES FOR NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES**
 - **J. CPT “Separate Procedure”** - If a CPT code descriptor includes the term “separate procedure”, the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a “separate

procedure” when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach.

- A CPT code with the “separate procedure” designation may be reported with another procedure if it is **performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach.**
- Documentation submitted included a consultation report along with a nerve and muscle table with results. A separate report for 95831 was not identified.
- Provider’s report submitted does not document a “separate procedure” for 95831 on date of service 11/20/2015.
- Based on coding guidelines and documentation reviewed, reimbursement of 95831 is not indicated.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes

Date of Service: 11/20/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
95913 & 95831	\$1415.00	\$0.00	\$408.82	1	\$0.00	Refer to Analysis

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 21.3	95861	95913	No

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