

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 9, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000764	Date of Injury:	08/23/2012
Claim Number:	[REDACTED]	Application Received:	05/20/2014
Claims Administrator:	[REDACTED]	Assignment Date:	07/22/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	95904		

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 \$250.00 for the review cost and \$564.41 in additional reimbursement for a total of \$814.41. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$814.41 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,

[REDACTED]
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
- AMA CPT 2013/2014

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 disputing \$0.00 reimbursement for Nerve Conduction Studies, CPT code 95904: Nerve conduction, amplitude and latency/velocity study, each nerve; sensory, for DOS 10/16/2013
- Initial EOR explanation of denial by the Claims Administrator, dated 04/01/2014 is as follows: The AAEM has taken the position that in order to conform to Medicare's regulations, a physician (MD, D) must provide the direct supervision throughout the performance of the NCV testing and must be immediately available to furnish the non-physician employee with assistance and direction, if needed, throughout the performance of the procedure, Please provide the name of the physician (MD or DO) who attended the testing.
- Second EOR explanation of denial by the Claims Administrator, dated 04/21/2014 is as follows: The charge exceeds the Official Medical Fee schedule. The charge has been adjusted to the allowance.
- 1st and 2nd EOR reimbursement for CPT 95904: \$0.00
- CMS 1500 submitted for DOS 10/16/2013 reflects CPT CODE 95904.
- 1st EOR reflects CPT Code 95904

- 2nd EOR reflect CPT Code 95940, Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure).
- 2nd EOR should have reflected submitted CPT Code 95904.
- Pursuant to Labor Code section 3209.3 the term “physician” includes “chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.”
- DWC’s position on Chiropractors is as follows: “In workers’ compensation, the chiropractor is statutorily defined as a ‘physician’ and may be reimbursed for medically necessary services within his scope of practice. The fee schedule statute, Labor Code section 5307.1, subdivision (a)(2)(A)(i) states, ‘[e]mployer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600.’ Under Labor Code section 4600, ‘Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer.’ The claims administrator must pay for medically necessary care rendered by a chiropractor; there is nothing in the fee schedule statute or regulations that limit chiropractic care to the limited scope of care covered by Medicare.”
- Claims Administrator is not disputing the actual service performed. The need for a “name of the physician (MD or DO) who attended the testing,” was required for reimbursement by the Claims Administrator, which is not a DWC requirement.
- Nerve conduction study (NCS) testing can be performed for different parts of a specific nerve or different segments of a different nerve to identify local pathological responses, if they exist. CPT code 95904 is reported only once when multiple sites on the same nerve are stimulated or recorded. If nerve conduction studies are performed on two different branches of a given motor or sensory nerve, then the appropriate code from the 95900-95904 series may be reported for each branch studied. From a CPT coding perspective, as long as the testing is performed on different nerves or different branches on the list (AMA CPT, 2013 Appendix J) multiple units should be reported.
- Provided NCV study confirmed the following nerve roots in accordance with the above referenced Appendix J:
 - L1R/L
 - L2R/L
 - L3R/L
 - L4R/L
 - L5R/L
 - S1R/L
 - S2R/L
- Seven Nerve Roots Abstracted from documentation.

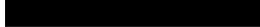
DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 95904.

Date of Service: 10/16/2013							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
95904	\$950.00	\$0.00	\$950.00	N/A	10	\$564.41	OMFS \$80.63 x 7 Units (Refer to Analysis) \$564.41 Due Provider

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