

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 11, 2014

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

IBR Case Number:	CB14-0000892	Date of Injury:	02/06/2002
Claim Number:	[REDACTED]	Application Received:	06/23/2014
Claims Administrator:	[REDACTED]	Assignment Date:	07/23/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	95913, 95886 x 2		

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: 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,

[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
- Negotiated contracted rates: PPO Discount 10%
- National Correct Coding Initiatives
- Other: OMFS Physician Fee Service

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 CPT codes 95913 and 95886.
- Claims Administrator reimbursed CPT code 95861 in the amount of \$181.25 according to OMFS less PPO discount of 10%.
- Provider submitted a Reconsideration letter dated June 19, 2014 that states after claim was paid, a corrected claim was sent on April 12, 2014 to the insurance company for Second Bill Review changing CPT 95861 to 95886 x 2 without any explanation of why Provider was changing the code. No documentation was received with the claim stating any reason for the change in code. Claims Administrator denied CPT 95886 x 2 indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day. (95861).”
- 95886 - Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure) Do not report 95886 in conjunction with 95860-95864, 95870, 95905. CPT 95886 is not to be reported with 95861 and therefore, no reimbursement of CPT 95886 x 2 is warranted.

- Provider also changed codes 95900, 95903 and 95904 to 95913 after first Explanation of Review indicated “We cannot review this service without necessary documentation. (Invalid code as billed. Resubmit with valid code.)
- CPT 95913 was denied by Claims Administrator indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day. (95861).”
- Based on NCCI Edits, 95861 and 95913 cannot be reported together pursuant to CPT Coding Guidelines. Therefore, reimbursement for CPT 95913 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code

Date of Service: 1/7/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
95913	\$361.90	\$0.00	\$361.90	N/A	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
95886	\$109.66	\$0.00	\$109.66	N/A	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
95886	\$109.66	\$0.00	\$109.66	N/A	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 20.0 1/1/2014-3/31/2014	95861	95886	Modifier Not Allowed
Physician Version Number: 20.0 1/1/2014-3/31/2014	95861	95910	Modifier Not Allowed
Physician Version Number: 20.0 1/1/2014-3/31/2014	95861	95913	Modifier Not Allowed
Physician Version Number: 20.0 1/1/2014-3/31/2014	95913	95910	Modifier Not Allowed

Copy to:

[REDACTED]
 [REDACTED]
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