

## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 4, 2015

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

IBR Case Number:	CB15-0001817-A	Date of Injury:	01/22/2014
Claim Number:	[REDACTED]	Application Received:	10/03/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/21/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	95913		

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 \$327.12 in additional reimbursement for a total of \$522.12. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$522.12 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, MD, MPH  
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: 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 of 95913, Nerve conduction studies; 13 or more studies.
- Claims Administrator denied code with indication “The testing results are needed in order to review this charge”
- Submitted for review was the Lower Extremity Study Electrodiagnostic Examination Report showing results for 12 sensory and motor nerves tested.
- CPT Assistant for 95913 - A nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded. Motor, sensory, mixed motor/sensory, or H-reflex tests are each counted per nerve tested.
- Letter dated March 30, 2015 shows Utilization Review Determination & Authorization for EMG/NCV Bilateral Lower Extremities, Begin Date: 3/26/2015, Expiration Date: 5/10/2015. Letter also states “The treatment noted above has been determined to be medically necessary”
- § 5307.11: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee

schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.

- Authorization dated March 30, 2015 is contract in nature. Therefore, reimbursement for 95912 is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 95912**

<b>Date of Service:</b> 04/21/2015						
<b>Physician Service</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
95912	\$739.90	\$0.00	\$369.95	1	\$327.12	<b>Refer to Analysis</b>

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]