
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 19, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001978	Date of Injury:	12/15/2014
Claim Number:	[REDACTED]	Application Received:	10/26/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/06/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	95869		

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 \$105.40 in additional reimbursement for a total of \$300.40. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$300.40 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 is seeking remuneration of 95869, Needle electromyography; thoracic paraspinal muscles for date of service 07/06/2015.
- Claims Administrator denied code indicating on the Explanation of Review “CCI: HCPCS/CPT procedure code definition” and “No separate payment was made because the value of the service is included within the value of another service performed on the same day.” Claims Administrator not disputing authorized services.
- Authorization not submitted for review.
- Referral dated 6/30/15 to Provider for “EMG/NCS and Neurodiagnostic Testing Consult, Bilateral, Lower Extremitie(s)” was submitted for review.
- As a pair code does exist between billed code 95869 and 95861, status indicator column shows ‘1’ which states that if an approved modifier is appended to the column 2 code, and documentation supports billed code, then the edit may be overridden.
- Provider appended approved modifier -59 to column 2 code 95869.
- Documentation includes dictated evaluation report and computerized results of studies reflecting 95869, Left Thoracic Paraspinal and Right Thoracic Paraspinal.
- Reimbursement of 95869 is warranted.
- Opportunity for Claims Administrator to Dispute Eligibility letter sent on 10/27/2015. A response from Claims Administrator was not received for this review.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 95869

Date of Service: 07/06/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
95869	\$321.44	\$0.00	\$175.28	2	\$105.40	\$105.40 Due to Provider

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]