

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 9, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000234	Date of Injury:	06/11/2013
Claim Number:	[REDACTED]	Application Received:	02/16/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/21/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	95887, 99214, and WC007-30		

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 \$103.59 in additional reimbursement for a total of \$298.59. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$298.5** 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, M.D., M.P.H.
Medical Director

[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
- AMA CPT
- OMFS

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 add-on Code 95887 Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (list separately in addition to code for primary procedure) and 99214-25, significant, separately identifiable Evaluation and Management and WC007-30 performed on 10/21/2015.**
- Claims Administrator denied 99214-25 and WC007-30 indicating on the Explanation of Review “**Services not authorized**”
- Article 5.3 Official Medical Fee Schedule §9789.12.12 (b) Consultation reports are bundled into the underlying evaluation and management visit code (c) (2) Consultation Services, separately reimbursable reports: Consultation reports requested by the Qualified Medical Evaluator (“QME”) or Agreed Medical Evaluator (“AME”) in the context of a medical-legal evaluation. Use WC007, Modifier -30
- Referral request from AME to Provider documents “EMG/NCV and Neuradiagnostic testing + Consult Report of bilateral upper and lower extremities”
- **Authorization from Utilization Review or Legal Parties to AME not submitted for review.**
- AME report dated August 24, 2015 shows “Treatment Recommendations: 2. Obtain updated EMG/NCV testing of the upper and lower extremities for a comparison study with previous images.”
- As AME authorization was not submitted, and AME report shows request for testing only, reimbursement of 99214 and WC007 is not warranted.

- Claims Administrator reimbursed Provider’s billed testing services which shows acceptance as “authorized.”
- **95887 AMA CPT Assist:** 95887 can also be used for examining **non-limb (axial)** muscles (e.g., intercostal, abdominal wall, cervical, thoracic and lumbar paraspinal muscles (unilateral or bilateral) regardless of the number of levels tested. However, it should not be billed when the paraspinal muscles corresponding to extremity are tested, and when the extremity codes 95860, 95861, 95863, or 95864 are reported.
- Parenthetical Guidelines specific to 95887: Use 95887 in conjunction with 95907-95913.
- Documentation reflects the following:
 - 95887 performed in connection with billed and reimbursed Parent Code 95913.
 - Electronic Report located on page 4 of the submitted visit documentation.
 - Right and Left Thor Paraspinal Muscles
 - Left and Right Lumbar Paraspinal Muscles
- Reimbursement is warranted for 95887.
- **Based on the aforementioned documentation and guidelines, reimbursement for 95887 is warranted.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 95887

Date of Service: 10/21/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
95887	\$180.12	\$0.00	\$103.59	1	\$103.59	Refer To Analysis

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