

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 11, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000244	Date of Injury:	05/16/2015
Claim Number:	[REDACTED]	Application Received:	02/16/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/27/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	95913 and 99354		

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 \$64.18 in additional reimbursement for a total of \$259.18. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$259.18** 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
- Official Medical Fee Schedule

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 95913 and 99354 for date of service 10/27/2015.**
- EOR's indicate denied service 99354 with indication "the charge was denied as the report/documentation does not indicate that the service was performed."
- MLN Matters Document MM5972 - Prolonged Services with Direct Face-to-Face Patient Contact Service - Documentation is required in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services billed. The medical record must be appropriately and sufficiently documented by the physician or qualified NPP to show that the physician or qualified NPP personally furnished the direct face-to-face time with the patient specified in the CPT code definitions. **The start and end times of the visit shall be documented in the medical record along with the date of service.**
- Documentation reflecting the Providers direct contact with Injured Worker "Face to face time with the patient was 1.5 hours additional 0.5 hours for electrodiagnostic testing;" the start and end times were not indicated on the document.
- Reimbursement of 99354 is upheld.
- RFA with request for EMG/NCV and Neurodiagnostic Testing identified in review.
- AMA CPT Code Description: 95913 Nerve Conduction studies; 13 or more
- Per AMA guidelines for nerve conduction studies: Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded.

- Documentation includes dictated evaluation report and computerized results of studies. Data and Interpreted Report indicate service 95913, specifically 14 nerve studies performed on the lower extremities.
- Contractual Agreement not submitted for review; EOR indicates PPO reduction of 85% OMFS.
 - **Based on the aforementioned documentation and guidelines, reimbursement is warranted for CPT 95913.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 95913 & 99354

Date of Service: 10/27/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
95913	\$790.00	\$250.29	\$91.91	1	\$314.47	\$64.18 Due to Provider
99354	\$420.00	\$0.00	\$105.75	1	\$0.00	Refer to Analysis

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

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