

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 9, 2016

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

IBR Case Number:	CB16-0000633	Date of Injury:	12/23/1997
Claim Number:	[REDACTED]	Application Received:	04/18/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/17/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	95913 and 95887		

[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 \$103.58 in additional reimbursement for a total of \$298.58. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$298.58** 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

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

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 additional remuneration for 95913, 13 or more Nerve Conduction Studies and 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), submitted for date of service 12/17/2015.**
- The Claims Administrator re-assigned 95913 to 95911 (9-10 studies) based on “**documentation submitted.**”
- AMA CPT Assistant Nerve Conduction Studies: For the purposes of coding, a single conduction study is defined as a sensory conduction test, a motor conduction test with or without an F wave test, or an H-reflex test. Each type of study (sensory, motor with or without F wave, H-reflex) for each nerve includes all orthodromic and antidromic impulses associated with that nerve, and constitutes a distinct study when determining the number of studies in each grouping (eg, 1-2 or 3-4 nerve conduction studies). Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded. The numbers of these separate tests should be added to determine which code to use. (CP T 2013, p 535)
- Nerve Conduction Study Results indicates four (4) sensory nerves tested on the lower extremities.
- Nerve Conduction Study Results indicates six (6) motor nerves tested on the lower extremities.
- Left and Right Plantar Motor (AHB) are included with Left and Right Tibial Motor Run #1 (AHB) and Right Peroneal TA Motor is included with Right Peroneal Motor (EDB), therefore, these nerves cannot be counted twice.
- Documentation for Nerve Conduction Study reflects 10 nerves studied.
- Based on nerve studies counted, reimbursement of 95913 is not warranted.
- EOR indicates 95887 denied based on documentation not reflecting level of service.

1. EMG Report indicates Right and Left Thoracic Paraspinus Rami tested.
- CCR § 9789.12.13. Correct Coding Initiative (a) The National Correct Coding Initiative Edits (“NCCI”) adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment. Claims Administrators shall utilize the National Correct Coding Initiative Coding Policy Manual for Medicare Services. If a billing is reduced or denied reimbursement because of application of the NCCI, the claims administrator must notify the physician or qualified non-physician practitioner of the basis for the denial, including the fact that the determination was made in accordance with the NCCI.
 - MUE’s for 95887 reflect 1 (one) allowable unit.
 - Contractual Agreement not received for IBR.
 - **Based on the aforementioned documentation and the review of the CPT descriptor, CPT code 95887 is documented and reimbursement is recommended.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 95913

Date of Service: 12/17/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
95913	\$686.90	\$294.46	\$75.50	1	\$266.04	Refer to Analysis
95887	\$360.24	\$0.00	\$207.18	1	\$103.58	\$103.58 Due to Provider

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