

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 28, 2016

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB16-0000342	Date of Injury:	05/21/2015
Claim Number:	[Redacted]	Application Received:	02/29/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	11/30/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99204, 95912, and 95887		

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 \$219.87 in additional reimbursement for a total of \$414.87. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$414.87** 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
- 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), 95912 Nerve conduction studies; 11-12 studies and 99204 performed on 11/30/2015.**
- Claims Administrator denied 99204 indicating on the Explanation of Review “Part of a retrospective review”
- **Referral request written on a prescription form was verified requesting the following service from Provider:**
 - **EMG/NCV and Neurodiagnostic Testing + Consult.**
- Original Authorization from Claims Administrator to referring physician shows request for testing only, reimbursement of 99204 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 Parent Code 95912.

- Electronic Report located on page 3 of the submitted visit documentation.
- Right Thor Paraspinal Muscle
- Reimbursement is warranted for 95887.
- **95912 AMA CPT Assist:** For the purposes of coding, a single conduction study is denied 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.
- Documentation supports 11 nerves studied.
- **Based on the aforementioned documentation and guidelines, reimbursement for 95887 and 95912 is warranted.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 95887 & 95912

Date of Service: 11/30/2015 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	\$103.59 Due to Provider
95912	\$593.54	\$210.84	\$116.28	1	\$327.12	\$116.84 Due to Provider

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