

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 30, 2015



IBR Case Number:	CB15-0000945	Date of Injury:	09/23/2013
Claim Number:	[REDACTED]	Application Received:	06/09/2015
Assignment Date:	07/07/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/19/2014 – 11/19/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99214, 95913, and 95867		

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 \$195.00 for the review cost and \$558.46 in additional reimbursement for a total of \$347.77. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$347.77** 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]

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 remuneration for 99214-25 Evaluation and Management service, 95913 Motor and/or sensory nerve conduction with interpretation and report, and 95887 Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) provided on November 19, 2014.**
- The Claims Administrator denied **99214-25, 95913, and 95887** services with the following rationale: “Unable to substantiate the billed service was rendered.”
- The determination of an Evaluation and Management service for Established Patients require at least **two of three** key components in the following areas (AMA CPT 1995/1997):
 - 1) **History, detailed:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
 - 2) **Examination, detailed:** “The 1995 documentation guidelines state that the medical record for a general multi-system examination should include findings about eight or more organ systems.”
 - 3) **Medical Decision of moderate complexity. Making Medical** decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:
 - a. The number of possible diagnoses and/or the number of management options that must be considered;
 - b. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and

- c. The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.
 - 4) **Counseling and/or coordination of care.**
 - a. With other qualified health care professionals, or agencies
 - b. Provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
- 1995/1997 Evaluation and Management Levels/Elements (History / Exam / Medical Decision Making), Established Patient:
 - 99212: Problem Focused / Problem Focused / Straight Forward
 - 99213: Expanded Problem Focused / Expanded Problem Focused / Low Complexity
 - 99214: Detailed History / Detailed Exam / Moderate Complexity
 - **99215 Comprehensive: extended HPI, ROS that is directly related to the problems identified in the HPI plus all additional body systems, and a complete PMFSH.**
- **Time:** In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services. The total length of time of the encounter (faced-to-face) should be documented and the record should **describe the counseling and/or activities to coordinate care.**

Additional Evaluation and Management information can be found in the AMA CPT code book or on-line at CMS.Gov.

- Abstracted information for date of service 11/19/2014 did not result in a separately identifiable level 4 Evaluation and Management service.

Time Factor for date of service:

- **25 minutes are typically spent face-to-face with the patient and/or family.**
- Based on the aforementioned documentation and guidelines, reimbursement for Evaluation and Management Level 99214 is not supported as there was no submitted report to reflect the Injured Worker seen for bilateral upper extremity pain and the Provider was not reimbursed for this service.
- The Claims Administrator denied **95913 and 95887** reimbursement stating the report "Unable to substantiate the billed service was rendered."
- CPT code 95913, Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report; 13 or more studies. Sedgwick downgraded 95913 to 95912. Reimbursement is supported for 95913 as there was a submitted report for this service supporting a total of 14 nerve studies.
- CPT 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. Code first nerve-conduction tests (95907-95913). Sedgwick downgraded 95887 to 95886, Reimbursement is supported for 95887 as there was a submitted report indicating the performance of a needle electromyography of non-extremity axial nerve supplied muscles done. Coded correctly with code 95887.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99214-25, 95913, and 95887

Date of Service: 11/19/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99214-25	\$232.26	\$0.00	\$232.60	N/A	1	\$0.00	Refer to Analysis
95913	\$686.90	\$312.99	\$48.91	N/A	1	\$361.90	\$48.91 Due Provider Refer to Analysis
95887	\$180.12	\$0.00	\$103.86	N/A	1	\$103.86	\$103.86 Due Provider Refer to Analysis

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