

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 21, 2015

██████████  
██████████  
████████████████████

Amendment to Final Determination of  
CB14-0001534. Please Note: 1)  
Additional "State" Claim Number:  
██████████ Listed on EOR and IBR  
Application 2) 2013 References

<b>IBR Case Number:</b>	CB14-0001534	<b>Date of Injury:</b>	07/31/2003
<b>Claim Number:</b>	██████████ (Listed on EOR)	<b>Application Received:</b>	10/14/2014
<b>Claims Administrator:</b>	██████████	<b>Assignment Date:</b>	02/23/2015
<b>Provider Name:</b>	████████████████████		
<b>Employee Name:</b>	████████████████████		
<b>Disputed Codes:</b>	76942		

██████████ :

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator's determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.**

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: ██████████  
██

## 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 2013

## 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 76942 Ultrasonic guidance services utilized for Pain Pump Refill needle placement (eg, biopsy, aspiration, injection, localization device), with imaging supervision and interpretation services, performed on 12/26/2013.**
- The Claims Administrator denied reimbursement with the following rationale: “Service/procedure is included in the value of another service performed on the same day.”
- EOR indicates the Claims Administrator reimbursed the Provider for billed service CPT 62370 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional).
- CPT 76942 code description includes “imaging supervision and interpretation.”
- A report of findings for the 76942 Ultrasound was identified within the ‘Primary Treating Physician Progress Report.’
- A separate copy of 3, 3 x 4 inch print images (copies) of the ultrasounds were reviewed – report not documented on the ultrasound photographs or a separate interpreted report.
- CPT 2013 guidelines for reporting 79642, “require a separate interpretation,” meaning a separate report from the Primary Physician Progress Report.
- Medicare Regulations Revision. **3227**, Chapter 13, section 20.1 for “**Professional Component**” (PC) states: “The interpretation of a diagnostic procedure includes a written report.”

- A separate written report for 76942 was not included with the IBR documentation.
- Based on the aforementioned documentation and guidelines, unable to recommend reimbursement as documentation to support the full service description of 76942 could not be identified.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: CPT 76942**

<b>Date of Service:</b> 12/26/2013							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
76942	\$495.39	\$0.00	\$148.44	N/A	1	\$0.00	<b>Refer to Analysis</b>

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