

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 27, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000524	Date of Injury:	04/03/2014
Claim Number:	[REDACTED]	Application Received:	03/30/2016
Assignment Date:	04/19/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/23/2015 – 11/23/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	0232T		

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: 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,

[REDACTED], 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
- 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 0232T Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed submitted for date of service 11/23/2015.**
- Services submitted to Claims Administrator on CMS-1500, place of service 11.
- CMS 1500 Reflects 0232T billed with CPT **76942** Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, and localization device), imaging supervision and interpretation.
- Procedure Documentation does not include Images for 0232T. Code description for 0232T indicates “including image guidance.”
- Authorization dated 09/23/2015 reflects the following authorized medical treatment:
 - Bilateral PRP Injections Under Ultrasound needle Guidance.
- Aforementioned authorization indicates medical treatment is authorized as per, “prevailing California Official medical Fee Schedule (OMFS), or Contractual Agreement, whichever is less. Payment is subject to applicable statutes and regulations, including, but not limited to, Labor Code §139.3 and §139.31.”
- EOR’s indicate “services disallowed based on **CPT Rules.**”
- NCCI edits indicate CPT 0232T is a column 2 code to column 1 CPT 76942.
 - CMS 1500 indicates **Modifier -59** appended to CPT 76942
 - Indicator of “0,” the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied. For PTP edits that have a CCMI of “1,” the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are “separate and distinct. Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used. (NCCI)
- **Modifier – 59: Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. (CPT)
- Documentation does not reflect CPT 0232T was separate and distinct from billed procedure 76942.
 - Procedure Documentation does not include Images for 0232T. Code description for 0232T indicates “including image guidance.”

- Procedure Documentation does not include Images or report for 76942.
- Procedure Documentation does not indicate outcome of 0232T and does not reflect interpretation of images used for “guidance.”
- Authorization reflects the treatment as authorized. However, the **authorization indicates that reimbursement for the authorized treatment is subject to current rules and regulations.** Abstracted information from submitted documentation indicates the criteria for 0232T reimbursement have not been met in accordance with the OMFS § 9789.12.13 Correct Coding Initiative and § 9789.12.10 (a) Coding; Current Procedural Terminology ©, Fourth Edition.
- Medicare Billing Manual, Page I6, paragraph 1: Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair, **the column two code is denied, and the column one code is eligible for payment.**
 - EOR’s indicated column 1 CPT, 76942, has been reimbursed.
- **Based on the aforementioned documentation and guidelines, reimbursement for 0232T is not indicated.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 0232T

Date of Service: 11/23/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
0232T	\$3,500.00	\$0.00	\$3,500.00	1	\$0.00	Refer to Analysis

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