

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

4/18/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator Name: [REDACTED]
Date of Disputed Services: 1/8/2013 – 1/8/2013
MAXIMUS IBR Case: CB13-0000285

Dear [REDACTED]

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/20/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:

The following evidence was used to support the decision:

- 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
- Other: OMFS Surgery General Information and Ground Rules

Supporting Analysis:

The dispute regards the denial of an Evaluation and Management service (99212 Modifier 25) and an ultrasound guidance procedure (76942). The Claims Administrator denied the billed procedure code 99212 Modifier 25 with the explanation "The documentation submitted does not identify significant, separately identifiable service greater than those usually required for the listed procedure." The Claims Administrator denied the billed procedure code 76942 with the explanation "Use of ultrasound code 76942 requires thorough evaluation of organ or anatomic region, image documentation and final written interpretation report per AMA CPT Book. Please submit S&I report."

The Independent Bill Review (IBR) application was forwarded to the Department of Workers' Compensation (DWC) for an eligibility review. The DWC deemed the IBR application eligible for the IBR process.

The Provider billed the following procedures for date of service 1/8/2013:

CPT 99212 – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: Problem focused history; problem focused examination; and straightforward medical decision making

CPT 76942 – Ultrasound guidance for needle biopsy

CPT 17000 – Destruction by any method including laser, with or without surgical curettement

CPT 93971 – Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study

CPT 36471 – Injecting of sclerosing solution; multiple veins, same leg

CPT 99080 – Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form

CPT 99085 – Special external photography for documentation of significant medical progress or condition may warrant an additional charge

CPT 99086 - Reproduction of chart notes

Modifier 25 – Significant separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service.

The Provider submitted a Progress Report (PR-2) and Request for Authorization, Sclerotherapy Procedure note; Duplex assessment; and Dermatology Progress Report. The PR-2 documented the diagnoses; status (improving); listed procedures performed; and working status. The documentation submitted did not demonstrate Evaluation and Management services above and beyond the services provided in the usual preoperative and postoperative care associated with the surgical procedures performed on date of service 1/8/2013. There is no reimbursement warranted for the billed procedure code 99212.

The second disputed code is the ultrasound guidance code 76942. Ultrasound guidance procedures require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized. A final, written report for the ultrasound guidance procedure should be issued for inclusion in the patient's medical record. The Claims Administrator requested a copy of the ultrasound image report. Per a review of the submitted documentation, a copy of the image documentation and final written report was not included. The Sclerotherapy Procedure Note did not include description of the ultrasound guidance procedure. The required documentation supporting the billing of the procedure code 76942 was not received; therefore, reimbursement is not recommended for the billed procedure code 76942.

There is no reimbursement warranted per the Official Medical Fee Schedule codes 99212 Modifier 25 and 76942.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99212	25	1	\$75.00	\$0.00	\$0.00	\$0.00	OMFS
76942		1	\$350.00	\$0.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Surgery General Information and Ground Rules, medical record and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$0.00 is upheld.

This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)

Sincerely,

██████████, RHIT

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