

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 5, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000475	Date of Injury:	02/03/2012
Claim Number:	[Redacted]	Application Received:	3/24/2014
Claims Administrator:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	76942-57		

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.

IBR Case Assigned: 6/01/2014

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 \$335.00 for the review cost and \$156.25 in additional reimbursement for a total of \$491.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$491.25 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,

[Redacted]
Chief Coding Reviewer

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
- Official Medical Fee Schedule
- Negotiated contracted rates: None
- National Correct Coding Initiatives
- Other: OMFS, AMA CPT 1997 & 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 dissatisfied with the denial of CPT code 76942.
- Claims Administrator denied reimbursement indicating on the Explanation of Review: “Per the AMA CPT Guidelines in the Radiology section, diagnostic ultrasound, it states that use of ultrasound, without a thorough evaluation of organ(s) or anatomic region, image documentation and a final written report is not separately reportable.”
- Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers’ Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers’ Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.
- Primary Treating Physician’s Progress Report (PR-2) was received which documents: “Patient returns today as a follow-up visit concerning her left shoulder...the patient is a 69 year old female status post left shoulder arthroscopy with SAD, distal clavicle excision, and SLAP lesion repair 3/19/13...ongoing pain in the shoulder, limiting her rehab” Provider noted examination of Left Shoulder Range of Motion with pain. Also mentioning Mild positive Neer and Hawkins Impingement test. Reason for ultrasound guidance is documented “Given the small anatomic space of the true intra-articular AC joint, and the necessity to obtain intra-articular placement of our medication, and the potential proximity of

neurovascular structures that we wished to avoid compromising, it was deemed medically necessary to utilize ultrasound guidance to assist with injection placement. All anatomic landmarks were identified.” Provider billed CPT code 76942 as both professional and technical components were observed.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on documentation received, reimbursement of CPT code 76942-57 is warranted for the amount listed below.

Date of Service: 10/09/2013						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
76942-57	\$662.49	\$ 0.00	\$ 156.25	1	\$ 156.25	DISPUTED SERVICE: Allow reimbursement of \$156.25

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