

**MAXIMUS FEDERAL SERVICES, INC.**

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

February 17, 2015

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

<b>IBR Case Number:</b>	CB14-0001714	<b>Date of Injury:</b>	07/31/2003
<b>Claim Number:</b>	████████████████████	<b>Application Received:</b>	11/14/2014
<b>Claims Administrator:</b>	████	<b>Assignment Date:</b>	12/17/2014
<b>Provider Name:</b>	██		
<b>Employee Name:</b>	████████████████████████████████████		
<b>Disputed Codes:</b>	76942		

Dear ████████████████████

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 reversed and the Claim Administrator owes the Provider additional reimbursement of \$250.00 for the review cost and \$245.00 in additional reimbursement for a total of \$371.97. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$371.97 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: ██████████  
Division of Workers’ Compensation (DWC) Medical Unit

## 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 76942 Ultrasonic guidance utilized for Pain Pump Refill needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation services performed on 06/12/2014.**
- The Claims Administrator denied reimbursement for 76942 stating: “Payment for this charge is not recommended without a statement documenting medical necessity.”
- Included for IBR is a dictated Secondary Physician Progress Report.
- CPT 76942 code description includes “imaging supervision and interpretation.”
- A report of findings for the 76942 Ultrasound was identified within the report entitled, “Secondary Physician Progress Report.”
- A separate copy of 3; 3 x 4 inch print images (copies) of the ultrasounds were reviewed.
- CPT 2014 guidelines for reporting 79642, “require a separate interpretation,” meaning a separate report from the ‘Secondary Physician Progress Report.’
- Medicare Regulations Revision. 2932, 04-18-14, 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 logic of the denial for 76942, the Claims Administrator would reimburse the Provider for this service if “medical necessity” was indicated.

