

**MAXIMUS FEDERAL SERVICES, INC.**

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

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**Independent Bill Review Final Determination Reversed**

12/27/2013

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 2/28/2013 – 2/28/2013  
MAXIMUS IBR Case: CB13-0000336

Dear [REDACTED] MD:

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/30/2013, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$527.57, for a total of \$862.57.**

**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
- Official Medical Fee Schedule or negotiated contract: PPO Contract
- Other: OMFS Surgery Ground Rules and Guidelines

**Supporting Analysis:**

The dispute regards the payment amount for a laser procedure (37799) performed on 2/28/2013. The Claims Administrator based its reimbursement of the billed procedure code 37799 on 96920 indicating "Based on the available information."

CPT 37799 - Unlisted procedure, vascular surgery. Per the Official Medical Fee Schedule, the procedure code 37799 does not have an assigned unit value and is considered a "By Report" code. Per the OMFS Surgery General Information and Ground Rules, procedures coded By Report are services which are unusual or variable. An unlisted service, or one that is rarely provided, unusual or variable, may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature or extent, and need for the procedure and the time, effort and equipment necessary to provide the service. By Report procedure values may also be determined by using the values assigned to a comparable procedure.

The Claims Administrator reimbursed the Provider based on CPT 96920. The description of CPT 96920 is "Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm." This code is not listed in the Official Medical Fee Schedule. The code does not describe the procedure performed.

The Provider submitted an Endovenous Laser Therapy (EVLT) Operative Report. The EVLT procedure is described as a minimally invasive laser procedure in treating varicose veins. The operative report described an Endovenous Laser treatment of an incompetent perforator vein. The vein was entered percutaneously under ultrasound guidance. The "Micron 600 reduced buffer fiber" was introduced and position was determined by ultrasound guidance and duplex imaging. The current CPT used to describe this procedure is 36478. The procedure code 36478 is not listed in the OMFS. The description of 36478 is "Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated."

Based on a review of the operative report and procedure description, the OMFS procedure codes comparable in description and scope are 37785, 76942 and 93971. The description of CPT 37785 is "Ligation, division, and/or excision of recurrent or secondary varicose veins (clusters), one leg." The description of CPT 76942 is "Ultrasonic guidance for needle biopsy." The description of 93971 is "Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study." The reimbursement of the CPT code 96920 by the Claims Administrator was not correct. The reimbursement should have been based on the comparable procedures listed in the OMFS as 37785, 76942 and 93971.

The reimbursement of \$527.57 is warranted per the Official Medical Fee Schedule codes 37785, 76942 and 93971.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date 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
37785		1	\$4,835.57	\$392.45	\$164.43	\$228.02	OMFS
76942		1	\$ .	\$156.25	\$0.00	\$156.25	OMFS
93971		1	\$ .	\$143.30	\$0.00	\$143.30	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT code 37785, 76942 and 93971 (\$527.57) for a total of \$862.57.

***The Claims Administrator is required to reimburse the provider \$862.57 within 45 days of date on this notice per section 4603.2 (2a). 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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