MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Independent Bill Review Final Determination Upheld

2/27/2014

[redacted]

Re: Claim Number: [redacted]
Claims Administrator name: [redacted]
Date of Disputed Services: 7/9/2013 – 7/9/2013
MAXIMUS IBR Case: CB13-0000590

Dear [redacted], MD:

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 11/12/2013, 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 Ground Rules and Guidelines

Supporting Analysis:
The dispute regards the payment amount for a laser procedure (37799) performed on 7/9/2013. The Claims Administrator based its reimbursement of the billed procedure code 37799 on 37720 indicating "The value of this BR procedure is based on 100% of 37720, which appears equal in scope and complexity to services rendered."

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 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 incompetent perforator vein. The incompetent perferator vein was entered percutaneously under ultrasound guidance. The "600 Micron Reduced buffer fiber" was introduced and position was determined by ultrasound guidance and duplex imaging. The current CPT used to describe EVLT 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.”

The Claims Administrator based its reimbursement on CPT 37720. The description of CPT 37720 is “Ligation and division and complete stripping of long or short saphenous veins.” The operative report did not indicate the Endovenous Laser treatment included the long or short saphenous vein. Based on a review of the operative report and procedure description, the OMFS procedure codes comparable in description and scope are 37785, 76942 Modifier 26 and 93971 Modifier 26. The description of CPT 37785 is "Ligation, division and/or excision of recurrent or secondary varicose veins (cluster), 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 Provider billed procedure code 93971 for date of service 7/9/2013 and received reimbursement for the procedure code 93971.

The claim form and medical record indicated the services were performed at an ambulatory surgery center. The professional component for the ultrasound guidance code (76942) was allowed based on the use of the place of service code 24 (Ambulatory Surgical Center) and location of services rendered.

There is no additional reimbursement warranted for the Endovenous Laser Treatment code 37799, based on the recommended OMFS codes (37785 and 76942 Modifier 26) and the Claims Administrator’s previous payment of $481.84.

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

Validated Code	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
37799 (37785 and 76942 26)	$4,518.16	$466.39	$481.84	$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:
This decision was based on OMFS Surgery Ground Rules and Guidelines, medical record and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of $481.84 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,

[redacted], RHIT

Copy to:
[redacted]

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