

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

3/20/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 8/22/2013 – 8/22/2013
MAXIMUS IBR Case: CB13-0000966

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 1/23/2014, 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 \$101.92, for a total of \$436.92.**

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: OMFS
- Other: OMFS General Information and Instructions, Surgery Ground Rules and Guidelines

Supporting Analysis:

The dispute regards the payment amount for a laser procedure (37799), report services (99080 and 99086) performed on 8/22/2013. The Claims Administrator based its reimbursement of the billed procedure code 37799 on 37720 indicating "The value of this procedure is based on 100% of 37720, which appears equal in scope and complexity to services rendered." The Claims Administrator denied the billed procedure code 99080 with the explanation "Last report paid PR2 8/15/2013; under 45 days; does not meet any of the guidelines on pg. 5 of the OMFS." The Claims Administrator denied the billed procedure code 99086 with the explanation "Chart notes/duplicate reports were not requested."

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. CPT 99080 – Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.
CPT 99086 - Reproduction of chart notes.

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 the short saphenous vein. The saphenous vein was entered percutaneously at mid-calf under ultrasound guidance. The "600 Micron 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."

Based on a review of the operative report and procedure description, the OMFS procedure codes comparable in description and scope are 37720, 76942 and 93971. The description of CPT 37720 is "Ligation and division and complete stripping of long or short saphenous veins." 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 CPT 37720 by the Claims Administrator was correct; however, the OMFS code 37720 does not include reimbursement for the ultrasound guidance or duplex scan procedures.

The claim form and medical record indicated the services were performed at an ambulatory surgery center. The professional components for the ultrasound guidance code (76942) and duplex imaging (93971) were allowed based on the use of the place of service code 24 (Ambulatory Surgical Center) and location of services rendered

The second disputed code is report code 99080. The Provider submitted a "Progress Report (PR-2), and Request for Authorization" report. A written request for a special report from the Claims Administrator was not submitted as part of the documentation. The type of report submitted by the Provider was not a Primary Treating Physician Progress Report (PR-2), or a separately reimbursable report as described in the OMFS General Information and Instructions Separately Reimbursable

Treatment Reports section, therefore, the denial of the report code 99080 by the Claims Administrator was correct.

The third disputed billed procedure is CPT 99086 "Chart Notes." Based on the OMFS General Information and Instructions, request for chart notes shall be in writing and be made only by the Claims Administrator. A request for chart notes from the Claims Administrator was not submitted as part of the documentation. Reimbursement for CPT 99086 is not warranted.

The reimbursement of \$101.92 is warranted per the Official Medical Fee Schedule codes 37799 (37720, 76942 26 and 93971 26). There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 99080 and 99086.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
37799(37720, 76942 26 and 93971 26)	1	\$4,518.16	\$583.76	\$481.84	\$101.92	PPO Contract
99080	1	\$60.00	\$0.00	\$0.00	\$0.00	PPO Contract
99086	3	\$90.00	\$0.00	\$0.00	\$0.00	PPO Contract

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 37799 (\$101.92) for a total of \$436.92.

The Claims Administrator is required to reimburse the provider \$436.92 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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