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

1/30/2014

[redacted]

Re: Claim Number: [redacted]
Claims Administrator name: [redacted]
Date of Disputed Services: 4/10/2013 – 4/10/2013
MAXIMUS IBR Case: CB13-0000444

Dear [redacted], MD:

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/2/2013, 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 $302.37, for a total of $637.37.**

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 General Information and Ground Rules

Supporting Analysis:
The dispute regards the payment amount for surgical procedures (17304,17999 59 x 2) for date of service 4/10/2013. The Claims Administrator reimbursed $208.08 on procedure code 17304 with the explanation "Procedure 15740 Flap procedure is @ 100% therefore 17304 is @ 50%. Reconsideration with no additional recommended allowance after reviewing your appeal. Primary procedure billed is 15740 done on the same session." The Claims Administrator reimbursed $94.29 for the billed procedure code 17999 with the explanation "The value of this procedure is based on 25% of 17107 (total sq cm for both parts), which appears equal in scope and complexity to services rendered. 3rd procedure."

CPT 17304 - Chemosurgery (Mohs' micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation; first stage, fresh tissue technique, of up to 5 specimens.
CPT 17999 - The description of the billed procedure code 17999 is "Unlisted procedure, skin, mucous membrane and subcutaneous tissue." Per the Official Medical Fee Schedule, the procedure code 17999 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.
Modifier 59 - Distinct Procedural Service.

The Provider submitted operative reports for the MOHs surgery (17304) and CO2 Matrix Fractional Ablative Laser Reconstructive Surgery (17999 x 2). The skin repair by adjacent tissue transfer procedures (Island Pedicle Flap CPT 15740 and Advancement Flap w/excision unkn CPT) was performed by a different physician of a different specialty (Plastic Surgery). A separate operative report was submitted for the Island Pedicle Flap and Advancement Flap with Excision procedures and the report documented a different attending surgeon's name. If surgeons of different specialties are each performing a different procedure, then multiple surgery rules do not apply. If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services. The Claims Administrator's decision to reduce the procedure (17304) to 50% as a secondary surgical procedure was not correct. The billed procedure code 17304 should have been reimbursed as the primary procedure at 100% of the PPO allowance.

The second disputed code is procedure code 17999 x 2. The Provider submitted separate operative reports for these procedures. The operative reports submitted by the Provider did not document an adequate procedure description, complexity or the amount of time required for the procedure. Based on the documentation submitted, a comparable procedure code or By Report allowance higher than the Claims Administrator's reimbursement of procedure code 17107 could not be determined. The areas treated were described as "Spot" with size of 9mm per "Spot."The description of 17107 is "Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 - 50.0 sq cm."

The Provider billed three surgical procedure codes for date of service 04/10/2013. The billed procedure codes should have been reduced according to multiple surgery guidelines as follows: 17304 (100%), 17107 (50%) and 11603 (25%). The Claims Administrator reimbursed the Provider 50% of the PPO allowance for procedure code 17304 and 25% of the PPO allowance for procedure

codes 17107 and 11603. The reimbursement should have been 100% of the PPO allowance for 17304 and 50% of the PPO allowance for 17107.

The additional reimbursement of $302.37 is warranted per the Official Medical Fee Schedule codes 17304 and 17107.

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
17304		1	$791.92	$416.16	$208.08	$208.08	PPO Contract
17107		1	$2905.71	$188.58	$94.29	$94.29	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 codes 17304 and 17107 ($302.37) for a total of $637.37.

The Claims Administrator *is required to reimburse the provider $637.37 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,

[redacted], RHIT

Copy to:
[redacted]

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