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

2/21/2014

[redacted]

Re: Claim Number: [redacted]
Claims Administrator name: [redacted]
Date of Disputed Services: 2/21/2013 – 2/21/2013
MAXIMUS IBR Case: CB13-0000522

Dear [redacted], MD:

Determination
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/22/2013, 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 General Information and Instructions

Supporting Analysis:
The dispute regards the denial of chart reproduction services (99086), photos (99085), report (99080) and a surgical procedure (17999) for date of service 2/21/2013. The provider billed CPT 99086, CPT 99085, CPT 99080 and CPT 17999, was reimbursed $489.60 and is requesting additional reimbursement of $4,810.40. The Claims Administrator reimbursed $489.60 for CPT 17999 with the explanation “17999 has been reimbursed using the value from a comparable code 17106 x 2.” The Claims Administrator denied reimbursement on CPT 99085 and CPT 99086 indicating "This service requires prior authorization and none was identified." The Claims Administrator denied reimbursement on CPT 99080 indicating "Reimbursement for this report is included with other services provided on the same day; therefore a separate payment is not warranted."

CPT 99086 - Reproduction of chart notes.
CPT 99085 - Special external photography for documentation of significant medical progress or condition may warrant an additional charge.
CPT 99080 - Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.
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.

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 second disputed code is the charge for photos billed as CPT 99085. Per the OMFS the procedure code 99085 is listed as a "By Report" service. Procedures without unit values or "By Report" are defined as "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, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service." The documentation to support the "By Report" separate reimbursement was not submitted. Services such as "photos" are considered procedures that are commonly carried out as an integral part of a total service, and does not warrant separate reimbursement. The denial of procedure code 99085 by the Claims Administrator was correct.

The Third disputed billed procedure code is CPT 99080. The Provider submitted a report titled Progress Report (PR-2) and Request for Authorization. The report documented the condition the patient was being treated for (709.00 and 709.2), the worker's progress (improving) and current medications and treatment. The report did not indicate the work status, authorization for treatment other than a follow-up visit in two weeks or change in the worker's condition, work status or treatment plan. The report submitted did not meet the requirements or description of a separately reimbursable

report as described in the OMFS General Information and Instructions Guidelines. The denial of the billed procedure code 99080 by the Claims Administrator was correct.

The fourth disputed code is procedure code 17999. The Provider submitted a separate operative report for this procedure. Per the operative report, procedure performed was CO2 Fractional Ablative Resurfacing, location was right leg, and the spot size was 18mm. Based on the documentation submitted, a comparable procedure code or By Report allowance higher than the Claims Administrator's reimbursement of $489.60 could not be determined. Based on a review of the explanation of review (EOR), it appears the reimbursement was based on the OMFS surgical procedure code 17106. The description of CPT 17106 is "Destruction of cutaneous vascular proliferative lesions (e.g. Laser technique); less than 10 sq cm."

There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 99086, 99085, 99080 and 17999.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99086	3	$90.00	$0.00	$0.00	$0.00	OMFS
99085	1	$150.00	$0.00	$0.00	$0.00	OMFS
99080	1	$60.00	$0.00	$0.00	$0.00	OMFS
17999	1	$4,810.40	$0.00	$489.60	$0.00	OMFS

Chief Coding Specialist Decision Rationale:
This decision was based on OMFS General Information and Instructions and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of $489.60 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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