

MAXIMUS FEDERAL SERVICES, INC.

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

Independent Bill Review Final Determination Reversed

10/17/2014

██████████
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IBR Case Number:	CB13-0000541	Date of Injury:	12/13/2009
Claim Number:	████████████████████	Application Received:	09/27/2013
Claims Administrator:	████████████████████		
Date(s) of service:	07/01/2013 – 07/01/2013		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	17999, 99080, 99086		

Dear ██████████

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 06/02/2014, 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 \$673.20 for a total of \$1,008.20.

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, AMA CPT 1997, §4603.5 and 5307.1

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Codes 17999, 99080, 99086 (3 units) are under review as these services were denied in full by the Claims Administrator, located in Tucson, AZ for the following reason: “Services not provided or authorized by designated (network/primary care) providers.”**
- Provider is seeking full remuneration for claim.
- Upon review of the documentation provided, it is noted that a document from the Claims Administrator located in Lake Mary, FL to the Provider, dated June 24, 2013 states the following: “The Provider has requested an extended date to complete the previously certified treatment/service. (Claims Administrator) has approved the extension requested as listed.”
- The following is the pertinent and relevant information as listed on the Authorization for billed service code 17999 (as listed on the Authorization):
 - Diagnosis 709.09, Other Dyschromia; 727.03, Trigger Finger; 941.2 Blister w/epid loss-brn fce head&nck; 943.2 Blister w/epid loss-burn upper limb; 944.3 Full-thick skn loss-burn wrst&hnd.
 - Procedure(s): 17999 Unlisted PX Skin Muc Membrane & Subo Tissue
96922 Laser Skin Disease Psoriasis> 500 SQ CM
 - Requested Treatment: Xtrac Laser Treatments x 30 Sessions **CERTIFIED**
 - Start Date of Certification: 14-Nov-2012
 - End Date of Certification: 30-Sep-2013
- Pursuant to Labor Code §4603.5 and 5307.1, the Administrative Director of the Division of Workers’ Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers’ Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.
- The first Authorized CPT code 17999 does not have an assigned unit value and is considered a "By Report" code under the OMFS. The second Authorized CPT Code, 96922, does not exist under the OMFS; pursuant to the Labor Code §4603.5 and 5307.1.
- Because the 2nd Authorized CPT Code does not exist under the OMFS for Out Patient Services at the time and date of the procedure, and the reported CPT Code, 17999 is a ‘By Report Code, a OMFS equivalent code can be utilized.
- The documentation provided has verified that the 07/1/2013 Xtract Laser Treatments x30 sessions had been authorized and the service was performed on the approved body parts of the injured worker during the authorized certification dates of 11/14/12 – 9/30/2013.
- OMFS Surgery General Information and Ground Rules states 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 a Progress Report (PR-2) and a Xtrac Laser Patient Treatment Log documented the treatment area of 228 sq. cm.” and areas treated, “R, L hand.”
 - CMS 1500 form points to diagnosis 709.09.
 - Replacement Code 17108 Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq, is a suggested replacement code as this code appears to be within the same scope and complexity of the services performed.
 - “By Report Code” Reimbursable at 100% of equal procedure code.
 - No PPO Contract included in the documentation, 100% OMFS will be utilized
 - OMFS for CPT 17108 is \$673.20
 - Total \$673.20 is the recommended reimbursement for CPT 17999 as 17108.
- CPT 99080 is listed on the OMFS as “Special Reports” code and is a By Report code.
 - The Provider submitted a report titled “Progress Report (PR-2) and Request for Authorization.” The report documented the patient was “improving” and “see attached reports.”
 - Attached report included a Xtrac Laser-Patient Treatment Log; documentation included in the value of the service for the procedure.
 - CMS 1500 form points to diagnosis 709.09; no separate diagnosis from procedure performed
 - 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.
 - Based on the documentation and guidelines, reimbursement is not warranted for CPT 99080.
- CPT Code 99086 x 3 units is listed as a By Report service. Per the OMFS, “Requests for chart notes shall be in writing and shall be separately reimbursable at \$10.00 for up to the first 15 pages. Pages in excess of 15 shall be reimbursable at \$0.25 per page. Chart note requests shall be made only by the claims administrator.”
 - No authorization in the documentation supplied for IBR could be found for this service.
 - The denial of procedure code 99085 by the Claims Administrator was correct.
- The table below describes the pertinent claim line information.
- **DETERMINATION OF ISSUE IN DISPUTE: Allow reimbursement of code 17999 as CPT 17108. PPO Contract was not received during IBR, OMFS utilized.**

Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amount	Notes
<i>Date of Service – 05/17/2013</i>						
<i>Outpatient Services</i>						
17999 as 17108	\$350.00	\$0.00	\$350.00	1	\$673.20	Refer to Analysis
99080	\$60.00	\$0.00	\$60.00	1	\$0.00	Refer to Analysis
99086	\$90.00	\$0.00	\$90.00	3	\$0.00	Refer to Analysis

Determination: REVERSED

Chief Coding Specialist Decision Rationale:

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 17999 (\$673.20) for a total of \$1,008.20

The Claims Administrator is required to reimburse the provider \$1,008.20 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 Signature]

[Redacted Signature]

[Redacted Signature]