

MAXIMUS FEDERAL SERVICES, INC.

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

Independent Bill Review Final Determination Upheld

4/23/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator Name: [REDACTED]
Date of Disputed Services: 7/18/2013 – 7/18/2013
MAXIMUS IBR Case: CB13-0000579

Dear [REDACTED]

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 11/4/2013, 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 General Information and Ground Rules

Supporting Analysis:

The dispute regards the payment amount for surgical procedures (11402 and 17999 Modifier 59) performed on 7/18/2013. The Claims Administrator reimbursed \$26.01 for the billed procedure 11402 with the explanation "Subject to multiple procedure guidelines and reimbursement as the third procedure at 25%. Same session no additional allowance recommended." The Claims Administrator reimbursed \$104.04 for the billed procedure code 17999 with the explanation "The value of this procedure is based on 50% of 17106, which appears equal in scope and complexity to services rendered."

CPT 11402 – Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or leg; lesion diameter 1.1 to 2.0 cm

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 is disputing the allowance of the billed procedure code 17999. The Provider submitted an operative report for the procedure code 17999. Per the operative report, procedure performed was CO2 Fractional Ablative Resurfacing, location was right upper back, 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 \$104.04 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."

The Provider billed three surgical procedure codes (13101, 11402 and 17999) for date of service 7/18/2013. The Claims Administrator reimbursed the procedure code 13101 at 100% of the listed value, procedure code 17999 at 50% of the listed value and procedure code 11402 at 25% of the listed value. The applied multiple surgery reduction by the Claims Administrator was determined to be correct. The primary procedure or highest valued procedure is CPT 13101, the second highest valued procedure is CPT 17999 (17106) and the third highest valued procedure is CPT 11402.

There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 17999 Modifier 59 and 11402.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates 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
17999	59	1	\$1,395.96	\$104.04	\$104.04	\$0.00	PPO Contract
11402		1	\$273.99	\$26.01	\$26.01	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Surgery General Information and Ground Rules, medical record and comparison with explanation of review. This was determined correctly by the Claims Administrator and the payment of \$130.05 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]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED] [REDACTED]
[REDACTED]