

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**Independent Bill Review Final Determination Upheld**

2/27/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 6/24/2013 – 6/24/2013  
MAXIMUS IBR Case: CB13-0000580

Dear [REDACTED], MD:

**Determination**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 11/7/2013, 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 (17999 Modifier 59, 11602 and 69100 Modifier 59 [2 unit]) for date of service 6/24/2013. The Claims Administrator based its reimbursement of the billed procedure code 17999 on procedure code 17106 with the explanation "The value of this procedure is based on 50% of 17106 which appears equal in scope and complexity to services rendered. Less than 10 sq. cm." The Claims Administrator reimbursed 11602 and 69100 (2units) with the explanations "Multiple procedures (25%)" and "Multiple procedure/3<sup>rd</sup> procedure (25%)."

The Provider billed the following surgical procedures for date of service 6/24/2013:

CPT 11602 – Excision, malignant lesion, trunk, arms, or legs; lesion diameter 1.1 to 2.10 cm.

CPT 13121 - Repair, complex, trunk; 2.6 cm to 7.5 cm.

CPT 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.

CPT 69100 – Biopsy external ear

Modifier 59 – Distinct procedural services

The Provider is disputing the reimbursement amounts for CPT 17999, 11602 and 69100.

The Provider submitted an operative report for the procedure code 17999. The operative report submitted 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 17106 could not be determined. The description of 17106 is "Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm."

The Provider billed four surgical procedure codes for date of service 6/24/2013. The Claims Administrator reimbursed the Provider according to the multiple surgical procedure guidelines; CPT 13121 (100%); CPT 17106 (50%); CPT 11602 (25%); CPT 69100 (25%); and CPT 69100 (25%). The billed surgical codes were reimbursed according to the PPO contract and multiple surgical procedure guidelines.

There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 17999, 11602 and 69100.

