

**MAXIMUS FEDERAL SERVICES, INC.**

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

3/20/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 7/3/2013 – 7/3/2013  
MAXIMUS IBR Case: CB13-0000704

Dear [REDACTED]

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/4/2013, 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 procedure (17999 59) performed in 7/3/2013. The Claims Administrator reimbursed \$220.32 for the billed procedure code 17999. The Claims Administrator's explanation of review (EOR) did not indicate a reason code for the reimbursement of procedure code 17999.

The Provider billed the following surgical procedures for date of service 7/3/2013:

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

CPT 13101- Repair, complex, trunk; 2.6 cm to 7.5 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 submitted an operative report for the CO2 Fractional Ablative Resurfacing procedure. Per the operative report, procedure performed was CO2 Fractional Ablative Resurfacing, location mid central back, and the spot size was 9mm. The operative report 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 \$220.32 could not be determined. Based on a review of the explanation of review (EOR), it appears the reimbursement was based on the PPO allowance for 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 code 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 Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
17999	59	1	\$1,279.68	\$220.32	\$220.32	\$0.00	PPO Contract

**Chief Coding Specialist Decision Rationale:**

This decision was based on OMFS Surgery General Information and Ground Rules and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$220.32 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]  
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