

**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**

10/20/2014

██████████  
████████████████████  
████████████████████

IBR Case Number:	CB13-0000822	Date of Injury:	09/25/2010
Claim Number:	██████████	Application Received:	12/06/2013
Claims Administrator:	██		
Date(s) of service:	08/19/2013 – 08/19/2013		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	17999, 99080, 99086 (x 3 units)		

Dear ██████████

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 07/03/2014, 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 \$90.00 for a total of \$425.00

**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

## ANALYSIS AND FINDING

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

- **ISSUE IN DISPUTE: Codes 17999, 99080, 99086 (x 3 units) are under review as these services were denied in full by the Claims Administrator.**
- **CPT 17999 “By Report” OMFS CPT Code:** Initially denied by the Claims Administrator on 10/09/2013 and again on 12/11/2013 due to “invalid” code status. However, the Claims Administrator reimbursed the Provider on 12/11/2013 for \$360.00 for the ‘invalid’ code, 17999.
- Provider is seeking full remuneration for 17999.
- 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.
- **CPT 17999** was utilized by the Provider for an Xtract Laser Treatment performed on an injured worker on 08/19/2013.
- **Authorization**, dated 06/27/2013 for the 10 Xtract Laser Treatments from 06/27/2013 through 08/27/2013, is acknowledged.
- The Provider submitted a Progress Report (PR-2) and an Xtract Laser Patient Treatment Log documenting the treatment and procedure for the authorized injured worker.
- Treatment was performed within the authorized time frame.
- 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.”
  - Replacement Code 17108 Destruction of cutaneous vascular proliferative lesions (e.g., 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 service performed for the of service in question.
  - “By Report Code” Reimbursable at 100% of equal procedure code.
  - OMFS \$500.00 x 90% PPO Contract = Total \$450.00 – Reimbursement \$360.00 = **\$90.00** Due Provider.
- **CPT 99080** is listed on the OMFS as “Special Reports” code and is a By Report code “Special reports such as insurance forms, more than the information conveyed in the usual medical communication or standard reporting form.”
  - Reimbursed by the Claims Administrator as OMFS CPT Code 99081 “Required Reports.”

- The Provider submitted a report titled “Progress Report (PR-2) and Request for Authorization.” The report documented the “improving” condition of the patient who was being treated for diagnosis code 696.1: Other psoriasis; noted on Operative Report.
- The report indicates the need for “additional laser treatments and follow up in “4 weeks.” other than a follow-up visit in two weeks or change in the worker's condition, work status or treatment plan.
- No documentation of insurance form completion
- No documentation other than the standard usual medical communication
- The report submitted did not meet the requirements or description of a separately reimbursable report. However, did meet the requirements for 99081, Required Reports
- Based on the documentation and guidelines, reimbursement is warranted for CPT 99081.
- OMFS \$11.69 x 90% PPO Contract = Total \$10.52 – Reimbursement = **\$0.00** Due Provider.
- 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 99086 by the Claims Administrator was correct.
- **DETERMINATION OF ISSUE IN DISPUTE: Allow reimbursement of code 17999 as CPT 17106. PPO Contract received during IBR, OMFS utilized.**

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

Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amount	Notes
<b>Date of Service – 08/19/2013</b> <b>Physician Services</b>						
17999(17108)	\$500.00	\$360.00	\$500.00	1	\$450.00	<b>OMFS \$500.00 x 90% PPO Contract = Total \$450.00 – Reimbursement \$360.00 = \$90.00 Due Provider. Refer to Analysis</b>
99080	\$60.00	\$10.52	\$60.00	1	\$10.52	<b>OMFS \$11.69 x 90% PPO Contract = Total \$10.52 – Reimbursement = \$0.00 Due Provider. Refer to Analysis</b>
99086	\$90.00	\$0.00	\$90.00	3	\$0.00	<b>Refer to Analysis</b>

**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 (\$90.00) for a total of \$425.00.

The Claims Administrator is required to reimburse the provider \$425.00 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,

  
Chief Coding Reviewer

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