

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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10/2/2013

**Independent Bill Review Final Determination Upheld**

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 1/30/2013 – 1/30/2013  
MAXIMUS IBR Case: CB13-0000115

Dear Miracle Mile Medical Center,

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 6/28/2013, 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 Outpatient Hospital Fee Schedule

**Supporting Analysis:**

The dispute regards the payment amount for surgical facility services on date of service 1/30/13. The facility services were billed on a UB-04/CMS 1450 using revenue code 490 and CPT 17999. The Provider was reimbursed a total of \$261.39 between the first and final explanation of review by the Claims Administrator. The Claims Administrator based its reimbursement of billed code 17999 on 17276 indicating "Based on the available information, hospital outpatient allowance was calculated as required under section 9789.33 of title 8, CCR."

The Provider is considered an ambulatory surgical center (ASC) and is located in Los Angeles. Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators."

The description of CPT 17999 is "Unlisted procedure, skin, mucous membrane and subcutaneous tissue."

The Claims Administrator's first explanation of review (EOR) indicated the facility services were adjudicated and payment of \$36.74 was issued based on the billed code 17999. Upon appeal, the Claims Administrator re-evaluated the billed services and issued an additional payment of \$224.65, indicating that reimbursement was based on CPT 17276. The description of CPT 17276 is "Destruction, malignant lesion, any method, scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm."

The operative report submitted indicated a pre-operative diagnosis as "Post Excisional Surgery wound." The operation performed was a CO2 Fractional Ablative Resurfacing. The location of the procedure was left mid clavicle and the anesthesia given was lidocaine with epinephrine. The description of the operative procedure was "The patient was taken back to the operative area and was prepped and draped in the usual fashion, following adequate anesthesia was obtained. The wound edges were treated with the CO2 fractional ablative laser. The power was 25 W, the density was 35%, the pulse duration was 2.0 ms, and the spot size was 9 mm. One pass was performed."

The Claims Administrator based its allowance on CPT 17276, which is a code for destruction of a malignant lesion over the size of 4 cm. The operative report does not indicate the size of the lesion is over 4 cm or that the lesion is malignant. Based on the documentation, the procedure performed appears to be more likely a scar revision of an existing surgical scar. There are very few CPT codes used for laser procedures and none for this procedure of a benign scar revision. The CPT 96999 code for an unlisted dermatologic procedure is most appropriate. The description of CPT 96999 is "Unlisted special dermatologic service or procedure."

The ASC allowance for CPT 96999 is \$25.37. The allowances for CPT 96999 and CPT 17999 are the same; therefore, no additional reimbursement is warranted.

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 Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
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17999			1	\$2463.26	\$25.37	\$261.39	\$0.00	OMFS
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**Chief Coding Specialist Decision Rationale:**

This decision was based on claim form, operative report and comparison with OMFS Outpatient Hospital Fee Schedule. This was determined correctly by the Claims Administrator and the payment of \$261.39 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,

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