

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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10/21/2013

Independent Bill Review Final Determination Upheld

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 1/9/2013 – 1/9/2013
MAXIMUS IBR Case: CB13-0000188

Dear [REDACTED] MD:

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 7/12/2013, 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 amount paid for surgical services (17999 Modifier 59). The Provider was reimbursed \$94.29 and is requesting additional reimbursement of \$1405.71. The Claims Administrator based its payment of billed procedure code 17999 on 17107 indicating "The value of this procedure is based on 25% of 17107-59, which appears equal in scope and complexity to services rendered."

CPT 17999 - Unlisted procedure, skin, mucous membrane and subcutaneous tissue.

CPT 17107 - Destruction of cutaneous vascular proliferative lesions (eg. laser technique); 10.0 - 50.0 sq cm.

Modifier 59 - Distinct procedural service.

The operative report submitted indicated a pre-operative diagnosis as "Post Mohs Excisional Surgery wound." The operation performed was a CO2 Fractional Ablative Resurfacing. The location of the procedure was mid forehead 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 15 mm. One pass was performed."

The Claims Administrator based its allowance on CPT 17107, which is a code for destruction of cutaneous vascular lesions between 10.0 to 50.0 sq cm. The operative report does not indicate the size of the area treated is over 10 cm or referred to as a lesion. Based on the documentation, the procedure performed appears to be more likely a scar revision of an existing surgical scar.

The Provider billed for the services using CPT 17999, which is a procedure without unit values (By Report). 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. 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 pricing could not be determined. The code assignment of CPT 17107 by the Claims Administrator was correct.

The Provider billed three surgery procedure codes for date of service 1/9/2013. The allowance for CPT 17107 Modifier 59 was reduced to 25% of the full allowance due to multiple procedure reduction guidelines.

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

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
17999	59		1	\$1405.71	\$94.29	\$94.29	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Surgery General Information and Ground Rules, procedure descriptions and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$94.29 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,

██████████, RHIT

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