

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

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11/5/2013

Independent Bill Review Final Determination Reversed

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 1/9/2013 – 1/9/2013
MAXIMUS IBR Case: CB13-0000276

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/19/2013, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$208.08, for a total of \$543.08.**

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
- Official Medical Fee Schedule or negotiated contract: PPO Contract
- Other: OMFS Surgery General Information and Ground Rules

Supporting Analysis:

The dispute regards the payment amount for surgical procedures (17311 and 17999) for date of service 1/9/2013. The Claims Administrator based the reimbursement of billed procedure code 17311 on 17304 indicating "The Official Medical Fee Schedule does not list 17311. An allowance has been made for a comparable service." The Claims Administrator based the reimbursement of billed procedure code 17999 on 17106 indicating "The value of this procedure is based on 25% of 17106, which appears equal in scope and complexity to services rendered."

17311 - Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks.

17999 - The description of the billed procedure code 17999 is "Unlisted procedure, skin, mucous membrane and subcutaneous tissue. Per the Original 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.

The Provider submitted a Mohs Surgery Operative Report. The operative report documented the "tumor was removed by Mohs surgery, fresh tissue technique in 2 stages, with 2 pieces of tissue processed for frozen section analysis." The billed procedure code 17311 is not listed in the Official Medical Fee Schedule (OMFS). The code listed in the OMFS comparable in value and scope is 17304. The description of procedure code 17304 is "Chemosurgery (Mohs' micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation; first stage, fresh tissue technique of up to 5 specimens." The code assignment of 17304 by the Claims Administrator was correct. The Claims Administrator's reimbursement was 50% of the PPO allowance for 17304. The billed procedure code 17304 is the primary procedure and should be reimbursed at 100%. The reimbursement of 17304 by the Claims Administrator was not correct.

The second disputed code is procedure code 17999. The Provider submitted a separate operative report for this 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 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 three surgery procedure codes for date of service 1/9/2013. The allowance for CPT 17106 was reduced to 25% of the full allowance due to multiple procedure reduction guidelines.

