

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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11/12/2013

Independent Bill Review Final Determination Upheld

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 3/4/2013 – 3/4/2013
MAXIMUS IBR Case: CB13-0000292

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/21/2013, 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 Guidelines

Supporting Analysis:

The dispute regards the payment amount for a surgical procedure (17999 Modifier 59) for date of service 3/4/2013. The Provider was reimbursed \$104.04 and is requesting additional reimbursement of \$1,395.96. The Claims Administrator based the reimbursement of billed procedure code 17999 on 17106 indicating "The value of this procedure is based on 50% of 17106, which appears equal in scope and complexity to services rendered. No additional allowance recommended after reviewing your appeal."

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. Modifier 59 – "Distinct procedural service."

The operative report submitted by the Provider did not document an adequate procedure description, complexity or the amount of time required for the procedure. The operative report documented "The wound edges were treated with 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 9mm. One pass was performed." 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 code assignment and reimbursement of CPT 17106 was correct.

The Provider billed seven surgery procedure codes for date of service 3/4/2013. The procedure was reduced correctly according to multiple procedure reduction guidelines. The documentation did not indicate a separate site, incision/excision or lesion. The allowance for CPT 17106 was reduced to 50% of the full allowance due to multiple procedure reduction guidelines.

There is no additional reimbursement warranted per Official Medical Fee Schedule code 17106.

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
17106	59		1	\$1395.96	\$104.04	\$104.04	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Surgery Guidelines and comparison with PPO Contract. This was determined correctly by the Claims Administrator and the payment of \$104.04 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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