

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280

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8/6/2013

**Independent Bill Review Final Determination Reversed**

[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 1/2/2013 – 1/2/2013  
MAXIMUS IBR Case: CB13-0000033

Dear [REDACTED],

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 6/7/2013, 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 \$122.85, for a total of \$457.85.**

**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: AMA CPT and OMFS

### Supporting Analysis:

The dispute regards the amount paid for a dermatology procedure, chart notes reproduction and completion of a report on 1/2/2013. The Provider billed CPT 17999, 99080 and 99086, was reimbursed \$377.15 and is now requesting an additional \$292.00. The Claims Administrator downcoded the billed code 17999 to 17107 indicating "The value of the procedure is based on 100% of 17107, which appears equal in scope and complexity to the services rendered." The Claims Administrator denied CPT 99080 indicating "This report does not fall under the guideline for separately reimbursable report found in the General Instruction Section of the Physician's Fee Schedule." The Claims Administrator denied CPT 99086 indicating "Chart notes/Duplicate reports were not requested."

The description of CPT 17999 is "Unlisted procedure, skin, mucous membrane and subcutaneous tissue." The description of CPT 99080 is "Special reports such as insurance forms, more than the information conveyed in the usual medical communication or standard reporting form." The description of CPT 99086 "Reproduction of chart notes." The description of CPT 17107 is "Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq. cm."

The Provider is utilizing the unlisted code CPT 17999 to bill for the XTRAC laser sessions. The provider submitted the XTRAC laser patient treatment log. The treatment log lists the date of service, location, dose setting and total body surface area of treatment. The treatment log indicated on date of service 1/2/2013 XTRAC laser treatment was performed on the worker's right hand and wrist for a total of 112 sq. cm.

Based on the documentation submitted the appropriate code assignment would be 17108. The description of CPT 17108 is "Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq. cm." The CPT 17108 is appropriate due to the size of the area treated.

The second disputed code is CPT 99080. The document submitted did not contain a report completed by the Provider for date of service 1/2/2013. The only report submitted with the documentation was for the initial evaluation on date of service 9/26/2011. Therefore, based on the documentation submitted additional reimbursement for CPT 99080 is not warranted.

The third disputed billed procedure is CPT 99086 "Chart Notes." Based on the OMFS General Information and Instructions, request for chart notes shall be in writing and be made only by the Claims Administrator. A request for chart notes from the Claims Administrator was not submitted as part of the documentation. Reimbursement for CPT 99086 is not warranted.

The documentation submitted did not support the code assignment of 17107 by the Claims Administrator. The code assignment of 17108 for the billed code 17999 is appropriate and warrants an additional reimbursement. The additional reimbursement is warranted per the PPO contract based on the following calculation:

PPO Allowance of 17108 = \$500.00 (lesser of fee schedule or physician charges)  
Previously Paid = \$377.15  
Total additional reimbursement due = \$500.00 – \$377.15 (previously paid) = \$122.85

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

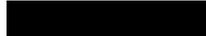
Validated	Validated	Validated	Validated	Dispute	Total Fee	Provider	Allowed	Fee Schedule
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Code	Modifier	Modifier	Units	Amount	Schedule Allowance	Paid Amount	Recommended Reimbursement	Utilized
17108			1	\$292.00	\$500.00	\$377.15	\$122.85	PPO Contract
99080			1	\$60.00	\$0.00	\$0.00	\$0.00	PPO Contract
99086			1	\$90.00	\$0.00	\$0.00	\$0.00	PPO Contract

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 CPT 17108 Modifier <MODIFIER> (\$500.00-377.15=122.85) for a total of \$457.85.

***The Claims Administrator is required to reimburse the provider \$457.85 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,

, RHIT

Copy to:



Copy to:

Division of Workers' Compensation Medical Unit  
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