

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**Independent Bill Review Final Determination Reversed**

6/18/2014

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IBR Case Number:	CB13-0000925	Date of Injury:	9/28/2009
Claim Number:	██████████	Application Received:	12/23/2013
Claims Administrator:	██████████		
Date(s) of service:	9/10/2013 – 9/10/2013		
Provider Name:	██████████ MD		
Employee Name:	██████████		
Disputed Codes:	17999, 99080 and J3301		

Dear ██████████ MD:

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 1/31/2014, 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 \$17.14, for a total of \$352.14.**

**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: California Workers' Compensation pharmacy fee schedule

**Supporting Analysis:**

The dispute regards payment amount for a surgical procedure (17999), denial of a report (99080) and injection (J3301) for date of service 9/10/2013. The Claims Administrator reimbursed \$377.15 for CPT 17999 with the explanation "Allowance was reduced as per contractual agreement." The Claims Administrator denied reimbursement of CPT 99080 with the explanation "The value of this procedure is included in the value of another procedure performed on this date." The Claims Administrator denied the HCPCS J3301 with the explanation "This code is deleted, non-covered, bundled, and invalid or the status indicator is not allowable under the Provider's jurisdiction."

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

CPT 99080 - Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.

CPT J3301 - Injection, triamcinolone acetonide, not otherwise specified 10 mg.

The Provider submitted an operative report for the CO2 Laser procedure. Per the operative report, procedure performed was CO2 Fractional Ablative Resurfacing, location was right face/neck, and the spot size was 18mm. Based on the documentation submitted, a comparable procedure code or By Report allowance higher than the Claims Administrator's reimbursement of \$377.15 could not be determined. Based on a review of the explanation of review (EOR), it appears the reimbursement was based on the OMFS surgical procedure code 17107. The description of CPT 17107 is "Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 – 50.0 sq cm."

The Provider submitted a report titled Progress Report (PR-2) and Request for Authorization. The report documented the condition the patient was being treated for (701.4), the worker's progress (improving) and current medications and treatment. The report did not indicate the work status, authorization for treatment other than a follow-up visit in one week or change in the worker's condition, work status or treatment plan. The report submitted did not meet the requirements or description of a separately reimbursable report as described in the OMFS General Information and Instructions Guidelines. The denial of the billed procedure code 99080 by the Claims Administrator was correct.

The third disputed code is HCPCS J3301. The operative report documented "Intralesional Kenalog 40mg/cc (2 cc), mixed with lidocaine 1% w/out epinephrine, injected into the keloidal scars. The Provider billed procedure code 11901 and J3301. The Claims Administrator reimbursed the Provider for the CPT 11901 and denied the billed charges for HCPCS J3301. Per the OMFS, Pharmaceutical injection materials administered during therapeutic, diagnostic, or antibiotic injections are separately reimbursable using the Pharmaceutical Formula. Based on the documentation, reimbursement is warranted for the billed HCPCS J3301. The reimbursement for the Kenalog 40mg/cc (2 cc) was determined using NDC 00003029328 "Kenalog-40 40mg/ml vial." The NDC and Metric Decimal Units (MDU) were entered into the Workers' Compensation Pharmacy Compound Prescription Calculator.

