

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

9/26/2014

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IBR Case Number:	CB13-0000947	Date of Injury:	01128/15/1980
Claim Number:	██████████	Application Received:	12/24/2013
Claims Administrator:	████████████████████		
Date(s) of service:	07/16/2013 – 07/16/2013		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	17002 & 90080		

Dear ██████████

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 04/02/14, 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 **\$261.72**, for a total of **\$596.72**.

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

Supporting Analysis:

Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers' Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.

The dispute regards the payment amount for destruction of lesion CPT Code 17002, x 18 units, performed and Special Report CPT Code 99080, for date of service 07/16/2013.

A claim for six (6) CPT codes were reviewed and processed by the Claims Administrator; the provider is questioning the reimbursement for two (2) of the six CPT codes. For the first portion of this review, three (3) CPT codes listed on the EOB will be presented below, as these codes are directly related with the first code in question, CPT 17002 x 18 units.

The Claims Administrator reimbursed \$0.00 for the billed CPT 17002 x 18 (units) with the explanations: 1) the charge exceeds the official medical fee schedule allowance. The Charge has been adjusted to the scheduled allowance. 2) This charge was adjusted to comply with the rate and rules of the contract indicated. 3) Billing is greater than surgical fees.

Current Procedural Terminology (CPT) 1997 defines the following CPT codes:

- **CPT 17000:** Destruction by any method, including laser, with or without surgical curettement, all benign facial lesions of premalignant lesions in any location, or benign lesions other than cutaneous vascular proliferative lesions, including local anesthesia; one lesion.
- **CPT 17001:** Destruction by any method, including laser, with or without surgical curettement, all benign facial lesions or premalignant lesions in any location, or benign lesions other than cutaneous vascular proliferative lesions, including local anesthesia; second and third lesions, each.
- **CPT 17002:** Destruction by any method, including laser, with or without surgical curettement, all benign facial lesions or premalignant lesions in any location, or benign lesions other than cutaneous vascular proliferative lesions, including local anesthesia; Over two lesions, each additional lesion.

The claims administrator reimbursed the physician for CPT Codes 17000 and add-on code 17001. CPT 17002 was denied for the reasons stated earlier. The EOB reflects reimbursement to the Provider for three cryosurgery procedures; 17000 and 17001 x 2 units and denied the remaining eighteen (18) units billed as 17002.

Upon review of the documentation, an anatomical diagram and procedure description, recorded by the physician for the date of service in question, clearly indicates that a total of twenty-one (21) lesions were treated. In the light of this documented evidence, reimbursement is warranted for the billed procedure code 17002 x 18.

The last code in question is CPT 99080 and is reimbursable under OMFS under certain circumstances. Title 8, California Code of Regulations, § 9795 provides some insight into these circumstances. A few examples are:

1. Final Treating Physician's Report of Disability Status
2. Primary Treating Physician's Permanent and Stationary Report.
3. Change in Work Status
4. Payable in addition to the underlying Evaluation and Management service for a consultation (CPT codes 99241-99245) or confirmatory consultation (CPT codes 99271-99275)

According to the documentation provided, the patient was seen for the following diagnoses:

1. 702.0 - Actinic keratosis,
2. 238.2 -Unc behav neo skin,
3. 173.3- Neoplasm skin of other and unspecified parts of face

On the date of service in question, the Provider also performed biopsies in addition to the destructions. These biopsies were also underlined on the previously mentioned PR2 form. The diagnosis codes were representative of the minor surgery procedure codes performed. The CPT code in question, CPT 99080 was assigned all of the codes. Since the report of findings for each CPT code is typically included into the procedure code itself, and there isn't, by § 9795 definition, a circumstance that warrants the need of CPT 99080, remuneration for this code is not recommended.

Since the PPO contract provided was incomplete and did not address the contractual reimbursement for CPT 17002 or 99080, the OMFS was utilized to determine cost.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
17002	18	\$810.00	\$261.72	\$0.00	\$261.72	OMFS
99080	1	\$60.00	\$0.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

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 code 17002 x 18 units (**\$261.72**) for a total of **\$596.72**.

The Claims Administrator is required to reimburse the provider **\$596.72** 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
Chief Coding Reviewer

Copy to:

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