

**MAXIMUS FEDERAL SERVICES, INC.**

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

**Independent Bill Review Final Determination Reversed**

7/30/2014

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████████████████████  
████████████████████

IBR Case Number:	CB14-0000141	Date of Injury:	11/1/1999
Claim Number:	██████████	Application Received:	2/6/2014
Claims Administrator:	██		
Date(s) of service:	8/26/2013 – 8/26/2013		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	17262 Modifier 59, 11100 Modifier 59, 17000, 17001 and 17002		

Dear ██████████

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/26/2014, 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 \$0.00, for a total of \$335.00.**

**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 (OMFS) or negotiated contract: PPO Contract
- Other: OMFS Surgery General Information and Ground Rules

### **Supporting Analysis:**

The dispute regards the payment amount for surgical services (17000, 17001, 17002, 11100 and 17262) performed on 8/26/2013. The Claims Administrator reimbursed \$9.76 for CPT 17000; \$12.36 for CPT 17001; \$83.54 for CPT 17002, and \$26.01 for CPT 11100 with the explanation “The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules.” The Claims Administrator reimbursed \$52.02 for the billed CPT 17262 with the explanation “Billing is greater than surgical service fee.”

The Claims Administrator sent MAXIMUS a letter dated 2/25/2014, indicating the Provider was reimbursed an additional amount of \$287.21 for the disputed codes 17001 and 17002. The additional payment by the Claims Administrator was issued after the Independent Bill Review case was received by MAXIMUS. The IBR application was received on 2/6/2014. The additional payment of \$287.21 was issued on 2/25/2014.

- **CPT 17000** – 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; 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 three lesions, each additional lesion
- **CPT 11100** – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure) unless otherwise listed (separate procedure); single lesion.
- **CPT 17262** – Destruction, malignant lesion, any method, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
- **Modifier 59** – Distinct Procedural Service

Per OMFS Surgery General Information and Ground Rules #8 Add-On Codes, some of the listed procedures are commonly carried out in addition to the primary procedure performed. All add-on codes found in CPT are exempt from the multiple procedure concept, rule number 7, and are reimbursed at 100% of their value. They should not be considered the primary procedure for the purposes of the surgical cascade. All add-on codes found in CPT are exempt from the multiple procedure concepts. They are exempt from the use of the Modifier “51” as these procedures are not reported as stand-alone codes. These additional or supplemental procedures are designated as “add-on” codes. Add-on codes in CPT can be readily identified by specific descriptor nomenclature which includes phrases such as “each additional” or “(List separately in addition to primary procedure).”

The billed CPT codes 17001 and 17002 include the descriptor “each” or “each additional” in the code description. These codes are not reported as stand-alone codes and are exempt from the multiple procedure concepts. The billed codes 17001 and 17002 should have been reimbursed based on 100% of the listed value minus any PPO discount. Additional reimbursement is warranted for the billed CPT codes 17001 and 17002.

The billed CPT code 17262 was reimbursed at 100% of the listed value minus a PPO discount. The second and third highest valued codes (11100 and 17000) were paid at 50% and 25% of their listed value minus a PPO discount. There is no additional reimbursement due for the billed CPT codes 17262, 11100 and 17000.

Based on the original documentation submitted, additional reimbursement was warranted for the Official Medical Fee Schedule codes 17001 and 17002. The explanation of review issued after the IBR was filed indicated the billed codes 17001 x 2 units and 17002 x 27 units were reimbursed at 100% of the listed value minus a PPO discount. Due to the additional reimbursement of \$287.21 was paid in full prior to the IBR Final Determination decision the only amount due by the Claims Administrator is the IBR application fee of \$335.00.

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

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
17262	59	1	\$247.98	\$52.02	\$52.02	\$0.00	PPO Contract
11100	59	1	\$123.99	\$26.01	\$26.01	\$0.00	PPO Contract
17000		1	\$85.24	\$9.76	\$9.76	\$0.00	PPO Contract
17001		2	\$77.64	\$49.42	\$49.42	\$0.00	PPO Contract
17002		27	\$1,131.46	\$333.69	\$333.69	\$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 codes 17001 and 17002 (\$0.00) for a total of \$335.00.

***The Claims Administrator is required to reimburse the provider \$335.00 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,

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[Redacted]  
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