

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

8/13/2014

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IBR Case Number:	CB14-0000184	Date of Injury:	2/1/2007
Claim Number:	██████████	Application Received:	2/13/2014
Claims Administrator:	████████████████████		
Date(s) of service:	9/25/2013 – 9/25/2013		
Provider Name:	██████████, MD		
Employee Name:	████████████████████		
Disputed Codes:	17999 59 x 2, 17000 59, 17001 59 x 2, 17002 59 x 23, 11100 59 and 11101 59 x 5		

Dear ██████████ MD:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/10/2014, 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 \$541.79, for a total of \$876.79.**

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: OMFS Surgery General Information and Ground Rules

Supporting Analysis:

The dispute regards the denial and reimbursement amounts for the following surgical procedures: 11100, Modifier 59; 11101, Modifier 59 x5; 17000, Modifier 59 x 2; 17001, Modifier 59 x2; 17002, Modifier 59, x23, and 17999 x2.

The Claims Administrator reimbursed \$104.04 for the billed CPT code 17999 x 2 with the explanation, "The value of this BR procedure is based on 25% of 17106 (lower scapular area – less than 10 sq. cm), which appears equal in the scope and complexity to services rendered. The value of this BR procedure is based on 25% of 17106 (Upper central forehead – less than 10 sq. cm), which appears equal in the scope and complexity to services rendered." The Claims Administrator denied the billed CPT Codes: 11100, Modifier 59; 11101, Modifier 59 x5; 17000, Modifier 59 x 2; 17001, Modifier 59 x2; 17002, Modifier 59 x23, with the following explanation on the initial and final explanation of review, "Service exceeds pre-authorized approval. Please provide documentation and/or additional authorization for the services not included in the original authorization. Unable to proceed (with) codes 11100, 11101 -59 x5, 17000, 17001 x2, 17002 x23 unless there is a retro authorization."

- **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 11100:** Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion.
- **CPT 11101:** Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure).
- **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
- **Modifier 59:** Distinct procedural service

The Provider submitted two separate operative reports for each of the 17999 procedures. Per the operative reports, procedure performed was CO2 Fractional Ablative Resurfacing, locations: Left lower scapular area and Upper central forehead, and the spot size was 6 mm (spot size for each location). Based on the documentation submitted, a comparable procedure code or By Report

allowance higher than the Claims Administrator's reimbursement of \$104.04 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 17106. The description of CPT 17106 is "Destruction of cutaneous vascular proliferative lesions (e.g. laser technique); less than 10 sq. cm." No additional reimbursement is warranted for the CPT 17999 x 2.

The documentation submitted included two Certification Recommendations (6041685-UMO-04 and 6041685-UMO-3) from the Utilization Review Company. The Certification 6041685-UMO-3 indicated the following: ICD9 702.0; diagnosis actinic keratoses; CPT: to be determined; validity date 4/11/2013-4/11/2014; requested/certified: skin biopsy; and requested/certified: destruction of actinic keratoses. The Certification 6041685-UMO-4 indicated the following: Diagnosis: squamous cell carcinoma, actinic keratosis; CPT: 21499, 17999; validity 4/16/2013 – 4/16/2014; requested/certified: Mohs Surgery; requested/certified: hemostic matrix kit; requested/certified: Skin repair of defect of the squamous cell carcinoma upper central forehead; requested/certified: fractionated laser resurfacing of wound edges; requested/certified excision and repair of the atypical nevus left lower scapular area; requested/certified: CO2 fractionated resurfacing of wound edges for atypical nevus left lower scapular area.

The Provider submitted a Cryosurgery/Electrodessication Operative report for date of service 9/25/2013. The Operative Report documented the Cryosurgery was performed on the following areas: Face (14); Ears (2); and Upper Extremities (10). Diagrams documenting the specific areas/lesions on the face, ears and upper extremities were also provided as documentation of services performed. Clinical diagnosis provided was Actinic Keratoses. The Certification 6041685-UMO-3 dated 4/11/2013 indicated the treatment of "Destruction of Actinic Keratoses" was authorized for dates 4/11/2013 thru 4/11/2014. Reimbursement is warranted for the billed CPT codes 17000, 17001 x 2 and 17002 x 23.

A Skin Biopsies Operative Report was submitted for the date of service 9/25/2013. The report documented the following: Clinical Diagnosis - Neoplasm of Uncertain Behavior 238.2; Locations: right lower back; left central back; left posterior shoulder; left jaw angle; right temple/hairline; and right mid outer arm; Operative Details: the lesions were biopsied, using shave technique. Aluminum Chloride was applied, the electrodesiccation of the biopsy sites wound beds was performed. The Certification 6041685-UMO-3 dated 4/11/2013 indicated the treatment of "Skin Biopsy" was authorized for dates 4/11/2013 thru 4/11/2014. The Certification did not indicate a specific anatomic site or location. Based on the Operative Report and Certification 6041685-UMO-3, reimbursement is warranted for the billed CPT codes 11100 and 11101.

Per the Official Medical Fee Schedule, multiple surgical procedures performed during the same session are reimbursed as follows: primary (highest valued procedure) 100% of listed value; secondary (second highest value) 50% of listed value; third procedure 25% of listed value. In addition to the disputed codes the Provider billed CPT codes: 13132; 17304; 17305; 13101; and 11601. Reimbursement for the disputed codes was calculated based on 25% of the listed value, with the exception of the add-on codes. Add-on codes are exempt from multiple procedure reduction and are reimbursed at 100% of the listed value.

The additional reimbursement of \$541.79 is warranted per the Official Medical Fee Schedule codes: 17000 Modifier 59; 17001 Modifier 59 x 2; 17002 Modifier 59 x 23; 11100 Modifier 59; and 11101 Modifier 59 x 5. There is no additional reimbursement warranted per the Official Medical Fee Schedule code 17999 (reimbursed as 17106) Modifier 59.

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
17999	59	2	\$2,895.96	\$104.04	\$104.04	\$0.00	PPO Contract
17000	59	1	\$95.00	\$9.76	\$0.00	\$9.76	PPO Contract
17001	59	2	\$90.00	\$49.42	\$0.00	\$49.42	PPO Contract
17002	59	23	\$1,035.00	\$284.26	\$0.00	\$284.26	PPO Contract
11100	59	1	\$150.00	\$13.01	\$0.00	\$13.01	PPO Contract
11101	59	5	\$375.00	\$185.34	\$0.00	\$185.34	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 17000, 17001, 17002, 11100 and 11101 Modifier 59 (\$541.79) for a total of \$876.79.

*The Claims Administrator is required to reimburse the provider \$876.79 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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