

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

8/19/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000217	Date of Injury:	11/6/1998
Claim Number:	[REDACTED]	Application Received:	2/20/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	6/24/2013 – 6/24/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	11101 59 and 17002		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/17/2014, 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 \$72.70, for a total of \$407.70.**

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: OMFS
- Other: OMFS Physician Services Fee Schedule

Supporting Analysis:

The dispute regards the payment amount for skin biopsy (11101 59 x 5) and denial of surgical destruction procedure (17002 x 5) performed on 6/24/2013. Seven (7) CPT codes were reviewed and processed by the Claims Administrator. The provider is questioning the reimbursement for two (2) of the seven CPT codes. For purposes of this review, five (5) CPT codes listed on the EOB will be presented, as these codes are directly related. The CPT codes in question will be reviewed here in two separate discussions/assessments. The Claims Administrator reimbursed \$133.59 for the billed CPT 11101 59 x 5 with the explanation "This charge was adjusted to comply with the rate and rules of the contract indicated. Billing is greater than surgical service fee." The CPT 17002 x 5 was denied reimbursement with the following explanation "This charge was adjusted to comply with the rate and rules of the contract indicated. Billing is greater than surgical service fee."

Current Procedural Terminology (CPT) 1997, Surgery Section Code Description:

- **CPT 11100:** Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure): single lesion
- **CPT 11101:** Each separate lesion
- **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:** Second and third lesions, each
- **CPT 17002:** Over two lesions, each additional lesion up to 15 lesions
- **Modifier 59:** Distinct Procedural Service

The Claims Administrator reimbursed the provider for the billed procedure codes 11100, 11101, 17000, 17001 and denied the procedure code 17002. The Provider is disputing denial of the billed procedure code 17002.

The Provider submitted a Cryosurgery/Electrodessication Operative report for date of service 6/24/2013. The Operative Report documented the Cryosurgery was performed on the following areas: Face (8). 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 Claims Administrator reimbursed the Provider for three cryosurgery procedures (17000 and 17002 x 2 units) and denied the remaining five (5) units billed as 17002. Per the documentation submitted, a total of eight (8) lesions were treated and reimbursement is warranted for the billed procedure code 17002 x 5.

The PPO contract agreement provided for this assessment did not have the CPT code in question listed (received 2 pages of CPT Codes); a determination regarding the adjustment presented could not be realized. Per the explanation of review, the reimbursement for the CPT 11101 59 x 5 was calculated based on the OMFS Physician services fee schedule of \$218.05, minus a PPO discount of \$84.46. . It appears that the reimbursement amount of \$133.59 for CPT Code 11101 -59 x 5, based solely upon the aforementioned guidelines and evidence presented, is considered to be within compliance of the associated fee schedules and PPO contractual agreement and does not support additional reimbursement.

CPT Code 17002 is a secondary code to 17000. The relative value for this secondary code has already been established and is, by its secondary nature, already calculated at a lower reimbursable rate than its parent. Additionally, CPT Code 17002 is also exempt from the multiple surgical procedure rule.

The PPO contractual agreement received between the provider and payor is incomplete and the actual contractual value cannot be determined. However, the OMFS fee schedule will be utilized to calculate the reimbursable amount of CPT Code 17002.

The additional reimbursement of \$72.70 is warranted per the Official Medical Fee Schedule code 17002 x 5. There is no additional reimbursement warranted per the Official Medical Fee Schedule code 11101 59 x 5.

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
11101	59	5	\$241.41	\$133.59	\$133.59	\$0.00	PPO Contract
17002		5	\$225.00	\$72.70	\$0.00	\$72.70	OMFS

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 17002 and 11101 Modifier 59 (\$72.70) for a total of \$407.70.

The Claims Administrator is required to reimburse the provider \$407.70 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

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