MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Independent Bill Review Final Determination Reversed

8/29/2014

[redacted]

IBR Case Number:	CB14-0000236	Date of Injury:	11/04/1973
Claim Number:	[redacted]	Application Received:	02/21/2014
Claims Administrator:	[redacted]		
Date(s) of service:	07/31/2013		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	17002 x 17 Units		

Dear [redacted],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/21/2014, 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 $247.18, for a total of $582.18**

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 destruction of lesion CPT Code 17002 x 17 units, performed on 07/31/2013. Seven (7) CPT codes were reviewed and processed by the Claims Administrator. The provider is questioning the reimbursement for one (1) of the seven CPT codes. For purposes of this review, three (3) CPT codes listed on the EOB will be presented below, as these codes are directly related.

The Claims Administrator reimbursed $0.00 for the billed CPT 17002 x 17 (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 service fee.

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 three 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 seventeen (17) units billed as 17002. An anatomical diagram and procedure description, recorded by the physician for the date of service in question, clearly indicates that a total of twenty (20) lesions were treated. In the light of this documented evidence, reimbursement is warranted for the billed procedure code 17002 x 17.

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. Therefore, reimbursement of $247.18 is warranted and recommended for the billed CPT 17002 x 17.

Since the PPO contract provided was incomplete and did not address the contractual reimbursement for CPT 17002, the OMFS was utilized to calculate this cost. The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
17002	17	$765.00	$247.18	$0.00	$247.18	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 code 17002 x 17 units (**$247.18**) for a total of **$582.18.**

The Claims Administrator *is required to reimburse the provider $582.18* ***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,

[redacted] RHIT
Chief Coding Reviewer

Copy to:

[redacted]

Copy to:

[redacted]