

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

October 29, 2014

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0000242	<b>Date of Injury:</b>	2/13/1978
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	2/21/2014
<b>Claims Administrator:</b>	[Redacted]		
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	17002 x 21		

Dear [Redacted]:

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

IBR Case Assigned: 08/11/2014

**Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$335.00 for the review cost and \$348.96 in additional reimbursement for a total of \$683.96. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$683.96 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

[Redacted]  
[Redacted]

cc: [Redacted]  
[Redacted]

## DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- 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

## HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

## ANALYSIS AND FINDING

**Based on review of the case file the following is noted:**

- **ISSUE IN DISPUTE:** Code 17002 x 21 units is under review as it was denied in full (or part) for SERVICE. Denied by the Claims Administrator for the following reasons: 1) “This appears to be a duplicate charge... A payment or denial has already been recommended for this service.” 2) The Charge Exceeds the Official Medical Fee Schedule Allowance. Directly related procedure codes submitted on CMS 1500 form: 17000 & 17001
- Current Procedural Terminology (CPT) 1997 defines the following related 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.
- **CPT 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-four (24) lesions were treated; 4 Ears, 10 Face, 10 Upper Extremities.

- EOR reflects two entries for 17002; 1 unit and 21 units.
- CMS 1500 form reflects one code of 17002 x 21 units.
- The Claims Administrator’s denial isn’t clear on whether the “maximum number of units allowed” is based on a Provider/Claims Administrator contractual agreement.
- Contractual Agreement not yet received, OMFS will be utilized.
- CPT Codes: 99212, 17000, 17001 x2, and 99080 are listed on the 2<sup>nd</sup> bill review but are not listed on the IBR. As such, these codes will not be reviewed.

**DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned guidelines and documentation provided, reimbursement is warranted for CPT 17002 x 21 units.**

Date of Service: 08/28/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers’ Comp Allowed Amt.	Notes
17002	\$945.00	\$ 0.00	\$945.00	N/A	21	\$348.96	OMFS \$14.54 x 21 = <b>\$348.96 due Provider</b>
17001	N/A	N/A	N/A	N/A	2		Code Not in Dispute
17000	N/A	N/A	N/A	N/A	N/A		Code Not in Dispute
99212	N/A	N/A	N/A	N/A	N/A		Code Not in Dispute
99080	N/A	N/A	N/A	N/A	N/A		Code Not in Dispute

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