

MAXIMUS FEDERAL SERVICES, INC.

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

Independent Bill Review Final Determination Upheld

10/2/2014

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

IBR Case Number:	CB14-0000266	Date of Injury:	03/14/1971
Claim Number:	██████████	Application Received:	02/26/2014
Claims Administrator:	██████████		
Date(s) of service:	09/26/2013		
Provider Name:	████████████████████		
Employee Name:	██████████		
Disputed Codes:	17002 x 23 Units		

Dear ██████████:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 4/3/2014, 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 upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

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
- Other: OMFS Physician Services

Supporting Analysis:

The dispute regards the payment amount for destruction of lesion CPT Code 17002 x 23 units, performed on 09/26/2013. Eight (8) codes were reviewed and processed by the Claims Administrator. The provider is questioning the reimbursement for one (1) of the eight CPT codes. For purposes of this review, three (3) CPT codes listed on the EOB will be presented and defined below as these codes are directly related.

American Medical Association Current Procedural Terminology (CPT), 1997:

- **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.

According to the EOR provided, the Claims Administrator reimbursed the Provider \$40.00 for billed CPT 17002 x 23 (units), with the following 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. 4) The recommended allowance is based on a PPO contract held with your facility (225).

The EOR reflects reimbursement to the Provider for three cryosurgery procedures; 17000 and 17001 x 2 units and twenty-three (23) units billed as 17002. CPT Codes 17000 and add-on code 17001 were reimbursed by Claims Administrator. CPT 17002 was reduced for the reasons stated earlier. The provider believes the reimbursement for CPT 17002 x 23 to be \$1,035.00 and is seeking reimbursement for the remaining \$995.00.

Upon review of the documentation provided, an anatomical diagram and procedure description, recorded by the physician for the date of service in question, clearly indicates that a total of twenty-six (26) lesions were treated. In the light of this documented evidence, reimbursement is warranted for the billed procedure code 17002 x 23.

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 rules.

In a review of the explanation of review (EOR), the services were reimbursed based on a PPO contract. The PPO contract submitted is incomplete and is missing pages containing the pricing allowances for the CPT code 17002. Since the Claims Administrator reimbursed the Provider \$40.00

for 23 units of 17002, and indicated the type of reductions applied based on the contractual agreement, a reimbursement calculation therefore, can be realized and used as a parameter for this review in lieu of the actual contractual agreement copy.

The EOR payment breakdown is as follows for CPT 17002 x 23 (units): reimbursement \$40.00; and PPO discount \$294.42. The Listed OMFS allowance for CPT 17002 x 23 (units) is \$334.42. Without the complete PPO contract, specifically the pages containing pricing information for the disputed code CPT 17002, the IBR reviewers were unable to recommend any additional reimbursement for CPT 17002 x 23 (units). Based on the EOR, it appears “the recommended allowance is based on a PPO contract held with your facility.” Therefore, the documentation presented did not support reimbursement of additional units for CPT 17002.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
17002	23	\$995.00	\$40.00	\$40.00	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on supplied medical record, explanation of review(s) and comparison with OMFS Physician Services Fee Schedule. This was determined correctly by the Claims Administrator and the payment of \$40.00 is upheld.

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
Chief Coding Reviewer

Copy to:

██████████
██
██

Copy to:

██
██
██