MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 4, 2014

[redacted]

IBR Case Number:	CB14-0000391	Date of Injury:	02/06/1999
Claim Number:	[redacted]	Application Received:	03/18/2014
Claims Administrator:	[redacted]		
Date(s) of service:	11/20/2013 – 11/20/2013		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	17304, 17305, 17999-59 x2 Units (C02 Laser) & 11602-59		

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.

Case assigned: 05/14/2014

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 $406.41 for the review cost and $335.00 in additional reimbursement for a total of $741.41. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $741.41 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]
Chief Coding Reviewer

cc: [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
- Negotiated contracted rates: PPO Contract

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 17304, 17305, 17999-59 (C02 Laser) & 11602-59, Provider is disputing reimbursement cascade. Provider believes 17304 and 17305 are the primary procedures.**
- Claims Administrator reimbursement message for each procedure code in question states: "Recommended payment reflects Physician Fee Schedule Surgery Section. Rule 7 guidelines for multiple or bi-lateral surgical services."
- Provided CMS 1500 form reviewed and verified:
- Date of Service: 11/20/2013
- Procedure Codes: 17304, 17305, 17999 (17107), & 11062 -59
- **Surgeon: 2 surgeons performing separately identifiable procedures.**
    - No mention of "Co-Surgeon" or "Co-Surgeon" agreement.
    - 1st Surgeon is a Dermatologist
    - 2nd Surgeon is a Plastic Surgeon
- OMFS procedure cascade is based on the weight of service codes then the multiple procedure rule is applied. The sequence of procedures according to OMFS guidelines are:
    - 17304 (3.2wt) **FIRST PROCEDURE**, Chemosurgery (MOHS Micrographic Technique), … first stage, fresh tissue technique, up to 5 specimens - Deleted 01/01/2007

    - 17999 [***17107**] (2.9wt) **SECOND PROCEDURE** 17999 Unlisted Code, Claims Administrator assigned comparable code 17107.
    - 17305 (1.5wt) **THIRD PROCEDURE** , Chemosurgery (MOHS Micrographic Technique), … second stage, fixed or fresh tissue, up to 5 specimens - Deleted 01/01/2007
    - 11062 (1.1wt) **FOURTH PROCEDURE**
- **CPT 17304 Primary Procedure**; Reimbursement is warranted for primary CPT Code 17304.
- [OMFS $489.00 X 85% PPO Contract] – Reimbursement $104.04 = $312.12
- **CPT 17999** Unlisted Code– Claims Administrator reimbursed code with the following message: "The value of this procedure is **based on 25% of 17107** Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq. cm, which appears equal in scope and complexity to services rendered."
    - Operative Report States, "…treated with the C02 fractional ablative laser… spot size was 6mm…." Replacement Code appears to be within the same scope and complexity of service performed.
    - **17999 x2 Units** is a "By Report Code" Reimbursable at 100% of equal procedure code.
    - ***Replacement Code 17107,** assigned by the Claims Administrator appears to be equal in scope and complexity of services rendered. As such, 17101 reimbursements is warranted as the **secondary procedure**.
    - Contract 25% of comparable code, 85% PPO discount, 50% Multiple Surgery Rule [OMFS $443.70 X PPO Contract x 50% Mult. Proc] = $94.29 Reimbursement $94.29 = $0.00 due provider.
- **CPT 17305**, Chemosurgery (Mohs micrographic technique): **third procedure**; Reimbursement is warranted for third CPT Code 17305.
        - [OMFS $229.50 X 85% PPO Contract x25%] – Reimbursement $195.08 = $0.00 due provider
- **CPT 11602 – 59,** Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm quaternary procedure;
    - Modifier – 59: "Distinct procedural service"
    - Reimbursement is warranted for fourth CPT Code 11602.[OMFS $168.30 X 85% PPO Contract] – Reimbursement $143.06 = $0.00 due provider

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE:
1.) Based on documentation and aforementioned guidelines additional reimbursement of is recommended for Primary CPT Code 17304
2.) Additional reimbursement is not warranted for CPT Codes 17999 (as 17107) x 2 Units, 17305 and 11602 – 59.

Date of Service: 111/20/2013							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
17304	$1,000	$104.00	$ 895.00	N/A	1	$ 416.16	OMFS $489.60 X 85% PPO Contract – Reimbursement $104.04 = **$312.12 Due Provider**
17999 as 17107	$3,000	$94.29	$2,905.71	N/A	2	$94.29	OMFS $443.70 x 2 Units x 25% & 85% PPO Contract x Mult. Proc = Total $94.29 - Reimbursement $94.29 = **$0.00 Due Provider.**
17305	$600.00	$195.08	$ 404.92	N/A	1	$195.08	OMFS $229.50 X 85% PPO Contract – Reimbursement $195.08 = **$0.00 Due Provider**
11062	$300.00	$35.77	$264.33	N/A	1	$35.76	OMFS $168.30 X 85 % PPO Contract x 25% Mult. Proc.– Reimbursement $35.76 = **$0.00 Due Provider**

Copy to:

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