

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 31, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000692	Date of Injury:	07/31/2002
Claim Number:	[Redacted]	Application Received:	05/06/2014
Claims Administrator:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	17002 x 19 & 99212-25		

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 assigned: 06/27/2014

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 \$250.00 for the review cost and \$189.02 in additional reimbursement for a total of \$439.02. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$439.02 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: Provider is disputing reimbursement for services 99212 and 17002 as the services were denied in full (or part) for service.**
- Code 17002 x 19 Denied in full by the Claims Administrator for the following reasons: 1) “The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the schedule allowance. 2) This charge was adjusted to comply with the rate and rules of the contract indicated.
- 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 sixteen (16) lesions were treated.
- Provider billed 19 units, only 13 units identified as 17002.
- Contractual Agreement not yet received during IBR as such, the OMFS will be utilized to determine reimbursement for CPT 17002.
- **CPT 99212-25:** The Claims Administrator denied in full CPT 99212 for the following reasons: 1) The Value of this procedure is included in the value of another procedure performed on this date. 2) No separate payment was made because the value of this service is in the value of another service performed on the same day.
- AMA CPT 1997 99212 Code Description: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components:
 - a problem focused history;
 - a problem focused examination;
 - straight forward decision making.
- Abstracted from the “Progress Report (PR-2)” for date of service 06/17/2013, it is documented that the Injured Worker was seen by the Provider for Actinic Keratosis and Cryosurgery was performed on the “face, ears,” and “upper extremities,” with a follow up visit in “6 months.”
- The PR-2 did not indicated a “significant, separately identifiable evaluation and management (E/M) service” in 06/17/2013 and the “three key components” of 99212 could not be identified.
- The Provider billed, a 99080 (Special Reports) and was reimbursed by the Claims Administrator for 99081(Required Reports).
- Since the Evaluation and Management Service performed on the same day of the procedure was not ‘significant, separately identifiable’ from the Cryosurgery, reimbursement is not warranted for CPT 99212-25.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE:

- 1) Reimbursement warranted for CPT 17002 x 13 units.
- 2) Reimbursement not warranted for 99212-25.

Date of Service: 06/17/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers’ Comp Allowed Amt.	Notes
17002	\$ 855.00	\$ 0.00	\$ 855.00	N/A	13	\$ 189.02	OMFS \$14.54 x 13 Documented Units (Refer to Analysis) = \$189.02 Due to

							Provider.
99212-25	\$ 75.00	\$ 0.00	\$ 75.00	N/A	1	\$ 0.00	Refer to Analysis

Copy to:

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