Determinations:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/16/2013, 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 $282.38, for a total of $617.38.

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: PPO Contract
- Other: OMFS Surgery General Information and Ground Rules
Supporting Analysis:
The dispute regards the payment amount for surgical procedures (17304, 17999 59, 11100 59 and 11101 59) for date of service 3/27/2013. The Claims Administrator reimbursed $208.08 for the billed procedure code 17304 indicating "Primary procedure 15740 recommended. 17304 is considered multiple 2nd procedure done under same session. No additional allowance recommended." The Claims Administrator reimbursed $52.02 for the billed procedure code 17999 indicating "the value of this BR procedure is based on 25% of 17106 (3rd multiple procedure), which appears equal in scope and complexity to services rendered. No additional allowance recommended." The Claims Administrator denied reimbursement on the billed procedure codes 11100 and 11101 indicating "Inclusive to the 17304 per CCI edit. No additional allowance recommended."

CPT 17304 - Chemosurgery (Mohs' micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation; first stage, fresh tissue technique of up to 5 specimens.
CPT 17999 - The description of the billed procedure code 17999 is "Unlisted procedure, skin, mucous membrane and subcutaneous tissue." Per the Official Medical Fee Schedule, the procedure code 17999 does not have an assigned unit value and is considered a "By Report" code. Per the OMFS Surgery General Information and Ground Rules, procedures coded By Report are services which are unusual or variable. An unlisted service, or one that is rarely provided, unusual or variable, may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature or extent, and need for the procedure and the time, effort and equipment necessary to provide the service. By Report procedure values may also be determined by using the values assigned to a comparable procedure.
CPT 11100 - Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure); unless otherwise listed (separate procedure); single lesion.
CPT 11101 - Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure); unless otherwise listed (separate procedure); each separate/additional lesion.
Modifier 59 - Distinct Procedural Service.

The Provider submitted an operative report for the MOHs surgery (17304). The Flap Repair (15740) was performed by a different physician of a different specialty (Plastic Surgery). If surgeons of different specialties are each performing a different procedure, then multiple surgery rules do not apply. If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services. The Claims Administrator's decision to apply the multiple surgery reduction guidelines to the primary procedure (17304) submitted by the Provider was not correct. The billed procedure code 17304 should have been reimbursed as the major procedure at 100% of listed value.

The second disputed code is procedure code 17999. The Provider submitted a separate operative report for this procedure. The operative report submitted by the Provider did not document an adequate procedure description, complexity or the amount of time required for the procedure. Based on the documentation submitted, a comparable procedure code or By Report allowance higher than the Claims Administrator's reimbursement of procedure code 17106 could not be determined. The description of 17106 is "Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm."

The third and fourth disputed surgical codes are 11100 and 11101. Per the OMFS code descriptions, both codes are identified as a Separate Procedures. The Provider billed both codes with the modifier

IBR Final Determination Reversed
Form Effective 7.22.2013
59. The Pathology Report documented the skin biopsy sites: Left mid cheek; and central upper forehead. The billed procedure codes (11100 and 11101) were identified as separate procedures and documented in the medical record as separate and independent procedures of the billed Mohs surgical code 17304. The Mohs Operative Report documented the Mohs procedure location as right lateral anterior crown. The denial of the billed procedure codes 11100 and 11101 by the Claims Administrator was not correct.

Based on the OMFS Surgery Guidelines, reimbursement for the multiple surgical procedures during the same sessions is as follows: 17104 (100%), 17106 (50%), 11100 (25%) and 11101 (25%). The additional reimbursement of $282.38 is warranted per the Official Medical Fee Schedule codes 17104, 17106, 11100 and 11101.

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

<table>
<thead>
<tr>
<th>Validated Code</th>
<th>Validated Modifier</th>
<th>Validated Units</th>
<th>Dispute Amount</th>
<th>Total Fee Schedule Allowance</th>
<th>Provider Paid Amount</th>
<th>Allowed Recommended Reimbursement</th>
<th>Fee Schedule Utilized</th>
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<tr>
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<td>$9.27</td>
<td>$0.00</td>
<td>$9.27</td>
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</tr>
</tbody>
</table>

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 codes 17304, 17999, 11100 and 11101 ($282.38) for a total of $617.38.

The Claims Administrator is required to reimburse the provider $617.38 within 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

Copy to:

[Redacted]
[Redacted]

Copy to:

[Redacted]
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