

**MAXIMUS FEDERAL SERVICES, INC.**

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

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**Independent Bill Review Final Determination Upheld**

1/28/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 3/28/2013 – 3/28/2013  
MAXIMUS IBR Case: CB13-0000409

Dear [REDACTED],

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/20/2013, 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 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 Outpatient Hospital Fee Schedule, National Correct Coding Initiative/Outpatient Code Editor Version 19.0 (1/1/2013-3/31/2013)

**Supporting Analysis:**

The dispute regards the payment for surgical facility services on date of service 3/28/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 17000 and CPT 11100. The Provider was reimbursed \$83.22 and is requesting additional reimbursement. The Claims Administrator reimbursed \$83.22 for the billed procedure code 17000. The Claims Administrator denied billed procedure code 11100 with the explanation, "Per CCI edits, the value of this procedure is included in the value of the comprehensive procedure."

CPT 17000 - Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); first lesion.

CPT 11100 - Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion.

The Provider is disputing the denial of the billed procedure code 11100.

Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers' Compensation orders that Title 8, California Code of Regulations, sections 9789.30 and 9789.31, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, is amended to conform to CMS' hospital outpatient prospective payment system (OPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (OPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. The adopted payment system addenda by date of service are found in the Title 8, California Code of Regulations, Section 9789.39(b). Based on the adoption of the CMS hospital outpatient prospective payment system (OPPS), CMS coding guidelines and the hospital outpatient prospective payment system (OPPS) were referenced during the review of this Independent Bill Review (IBR) case.

NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances. If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together when the two procedures are performed at different anatomic sites or different patient encounters. NCCI-associated modifiers may be utilized to allow payment of both codes of an edit. The documentation must support the use of the modifier. Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI edit include: Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI; Global surgery modifiers: 24, 25, 57, 58, 78, 79; other Modifiers: 27, 59, and 91. The billed surgical procedures 17000 and 11100 were not billed with any of the above Modifiers. During certain surgical procedures on the integumentary system: excision, destruction, or shave removals, removed tissue is often submitted for pathological examination. The obtaining of tissue during the course of these procedures is a routine component of such procedures. The CPT 11100 is included in or cannot be reported with 17000, unless circumstances warrant the reporting of 11100 separately. The Provider indicated Modifier 59 on the Second Bill Review request, however, the medical record documentation submitted did not support the use of Modifier 59.

The Provider submitted a Primary Treating Physician Progress Report (PR-2), Progress Notes and a Pathology Report. The Pathology report documented the location of the biopsy (11100) as "R Forehead/Hairline." A separate operative report was not received as part of the documentation for the billed procedure code 17000. The progress notes submitted were handwritten and the documentation regarding the location of the dermatological service billed as 17000 was not apparent. The only location identified on the progress notes was the "R Forehead/Hairline." Based on the

submitted documentation, it is not apparent nor documented that the surgical services (17000 and 11100) were performed on different sites, different lesions or during different patient encounters. The billed CPT 11100 is included in the reimbursement of the billed CPT 17000. The denial of the billed procedure code 11100 by the Claims Administrator was correct.

There is no additional reimbursement warranted per the Official Medical Fee Schedule code 11100.

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

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
11100		1	\$150.00	\$0.00	\$0.00	\$0.00	OMFS

**Chief Coding Specialist Decision Rationale:**

This decision was based on Official Medical Fee Schedule (OMFS) Outpatient Hospital Schedule and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$0.00 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

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