

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

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Independent Bill Review Final Determination Reversed

1/17/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED] 8
Claims Administrator name: [REDACTED]
Date of Disputed Services: 3/27/2013 – 3/27/2013
MAXIMUS IBR Case: CB13-0000422

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/25/2013, 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 \$151.18, for a total of \$486.18.**

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: OMFS
- Other: Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 3/27/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 17311, 11100, 11101, 15740 and 17999. The Provider was reimbursed \$1,240.02, and is requesting additional reimbursement of \$2,712.65. The Claims Administrator reimbursed the Provider \$1,227.67 for CPT 17311 and 15740. The Claims Administrator reimbursed the Provider \$12.35 for the billed procedure code 17999 with the explanation "No other documentation provided for this service. Allowed per Fee Schedule. No additional fee allowed." The billed procedure codes 11100 and 11101 were denied with the explanation "Biopsy was done on the same day as Moh's surgery. Inclusive to primary surgery procedure per CCI edits. This is included in 17311. No additional fee is owed."

The Claims Administrator reimbursed the primary procedure code 15740 at 100% of the OMFS Outpatient Hospital and Ambulatory Surgery Center allowance, secondary and third procedures 17311 and 17999 at 50% of the OMFS Outpatient Hospital and Ambulatory Surgery Center allowance. The Provider is disputing the denial of the billed procedure codes 11100 and 11101, and the reimbursement amount of the billed procedure code 17999.

CPT 17311 - 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 histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks.

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

CPT 11101 - Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure).

CPT 15740 - Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel.

CPT 17999 - 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.

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.

The provider is considered an ambulatory surgical center (ASC) and is located in Alameda county. Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators." The CPT 17311, 11100, 11101, 15740 and 17999 have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. All other billed supplies, drugs and services were considered an integral part of an the billed surgical procedures and not separately reimbursable.

The Provider submitted the following reports: MOHs Surgery Operative Report (17311); Skin Biopsies Operative Report (11100 and 11101); Skin Repair by Adjacent Tissue Transfer (15740); and CO2 Matrix Fractional Ablative Laser Reconstructive Surgery Operative Report (17999). The Skin Biopsies Operative 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.

The third disputed code is procedure code 17999. The Provider submitted a separate operative report for this procedure. Per documentation submitted by the Claims Administrator, the Provider's professional fees for the billed procedure code 17999 for date of service 3/27/2013 were reviewed and reimbursed based on the CPT code 17106. The description of 17106 is "Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm." Based on the documentation submitted, the CPT 17106 appears to be comparable in description and scope to the billed laser procedure code 17999. The reimbursement for the billed procedure code 17999 should have been based on the procedure code 17106.

Based on the OMFS Outpatient Prospective Payment System (OPPS) Multiple Surgery Guidelines, reimbursement for the multiple surgical procedures during the same sessions is as follows: 15740 (100%), 17311(50%), 17106(50%), 11100 (50%) and 11101 (50%). The additional reimbursement of \$151.18 is warranted per the Official Medical Fee Schedule codes 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.

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
15740	1	\$0.00	\$1,066.24	\$1,066.24	\$0.00	OMFS
17311	1	\$0.00	\$161.43	\$161.43	\$0.00	OMFS
17106	1	\$2,487.65	\$87.84	\$12.35	\$75.49	OMFS
11100	1	\$150.00	\$47.72	\$0.00	\$47.72	OMFS
11101	1	\$75.00	\$27.97	\$0.00	\$27.97	OMFS

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 17106, 11100 and 11101(\$151.18) for a total of \$486.18.

The Claims Administrator is required to reimburse the provider \$486.18 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,

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