

MAXIMUS FEDERAL SERVICES, INC.

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

Independent Bill Review Final Determination Reversed

1/30/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 4/19/2013 – 4/19/2013
MAXIMUS IBR Case: CB13-0000436

Dear [REDACTED],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/30/2013, 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 \$270.52, for a total of \$605.52.**

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 4/19/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 17004, CPT 11100 and CPT 11101. The Provider was reimbursed \$288.55 and is requesting additional reimbursement. The Claims Administrator reimbursed \$288.55 for the billed procedure code 17004. The Claims Administrator denied the billed procedure code 11100 with the explanation, "Per CCI edits, the value of this procedure is included in the value of the comprehensive procedure." The Claims Administrator denied the billed procedure code 11101 with the explanation "This add-on code has been denied as the principal procedure was not billed."

CPT 17004 - Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); fifteen or more lesions.

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).

The Provider is disputing the denial of the billed procedure code 11100 and 11101.

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.

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 codes 17004, 11101 and 11100 have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. The APC weights are determined by the APC code assigned by the Outpatient Prospective Payment System Calculator.

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 17004 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 and CPT 11101 is included in or cannot be reported with 17004, unless circumstances warrant the reporting of 11100 and 11101 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 for all billed biopsied procedures (CPT 11100 and 11101 x 3).

The Provider submitted a Skin Biopsies Operative Report, Cryosurgery/Electrodesiccation Operative Report, Dermatology Progress Notes and a Pathology Report. The Pathology report (11100 and 11101) documented the location of the biopsies: Proximal forearm; Upper sternum; L upper sternum; and L lateral clavicle/neck. The Cryosurgery/Electrodesiccation Operative Report (17004) indicated the location of treatment was the "face and upper extremities." The documentation regarding the location of the Cryosurgery (17004) performed on the upper extremities was not specific. The documentation did not indicate that the biopsy (11101) performed on the "Proximal Forearm" was not included in the Cryosurgery (17004) treatment on the "upper extremities." No other documentation was submitted that identified the specific areas treated on the "upper extremities" with the Cryosurgery (17004). Reimbursement is warranted for three of the biopsy procedures (11101, 11100 x 2): Upper sternum; L upper sternum; and L lateral clavicle/neck. Reimbursement is not warranted for the biopsy procedure (11100): Proximal forearm.

The CPT code 11101 is an "Add on Code." The primary code is 11100 and was billed in conjunction with 11101. The "Add on Code" 11101 is exempt from multiple procedure concept.

The additional reimbursement of \$270.52 is warranted per the Official Medical Fee Schedule Outpatient Hospital Fee Schedule codes 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 Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
11100		1	\$150.00	\$73.60	\$0.00	\$73.60	OMFS
11101		2	\$225.00	\$196.92	\$0.00	\$196.92	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 11100 and 11101 (\$270.52) for a total of \$605.52.

The Claims Administrator is required to reimburse the provider \$605.52 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]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED] [REDACTED]
[REDACTED]