

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

7/11/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000440	Date of Injury:	2/1/2007
Claim Number:	[REDACTED]	Application Received:	9/6/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	3/27/2013 – 3/27/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	11100, 11101 and 17999		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/2/2013, 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 \$75.50, for a total of \$410.50.**

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 (OMFS) or negotiated contract: OMFS
- 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 3/27/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 17311, 15740, 17004, 17999 11100 and 11101. The Provider is disputing the payment amount of CPT 17999 and the denial of CPT 11100 and 11101. The Claims Administrator reimbursed \$12.35 for the billed procedure code 17999 with the explanation "Allowance/Review determined by Professional Review." The Claims Administrator denied billed procedure code 11100 with the explanation, "Biopsy was done on the same day as Moh's surgery. Inclusive to primary surgery procedure per CCI Edits." The Claims Administrator denied billed procedure code 11101 with the explanation "Included in another billed procedure."

- **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) (eg, 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 15740:** Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel
- **CPT 17004:** Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
- **CPT 17999:** Unlisted procedure, skin, mucous membrane and subcutaneous tissue
- **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 submitted a separate operative report for the CO2 Fractional Ablative Resurfacing (17999) procedure. Per the operative report, procedure performed was CO2 Fractional Ablative Resurfacing, location was right upper forehead, and the spot size was 6mm. The Claims Administrator submitted a letter dated 9/30/2013 indicating the reimbursement for the billed code 17999 was based on CPT 17106; however, according to the explanation of review (EOR) a payment of \$12.35 for the billed laser procedure (17999) was issued. The reimbursement of \$12.35 is not based on the OMFS Outpatient Hospital and Ambulatory Surgery Center fee schedule for CPT 17106. In reviewing the medical record it was determined that CPT 17106 is appropriate based on the service described in the operative report. The description of CPT 17106 is "Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm." Additional reimbursement is warranted for the billed laser procedure based on the CPT 17106 and is subject to multiple procedure reduction guidelines. The recommended allowance for CPT 17106 is based on 50% of the OMFS allowance.

The Provider is disputing the denial of the billed biopsy codes 11100 and 11101(3units). The Skin Biopsy Operative Report documented the locations of the four biopsies as: Upper central forehead; vertex; right hand dorsum; and left lower scapular area. The Operative Details: The lesions were biopsied, using shave technique. Per the Cryosurgery Operative report, the billed cryosurgery procedures (18 procedures) CPT 17004, were performed on the following locations: Face; ears; and

upper extremities. The Mohs surgery Operative Report was not submitted as part of the documentation.

Per coding guidelines, certain surgical procedures in the integumentary system, such as excision, destruction, or shave removals, the removed tissue is often submitted for pathologic examination. The obtaining of tissue for pathology during the course of these procedures is a routine component of such procedures. This obtaining of tissue is not considered a separate biopsy procedure and is not separately reported. The use of a biopsy procedure code (eg, 11100, 11101) indicates that the procedure to obtain tissue for pathologic examination was performed independently, or was unrelated or distinct from other procedures/services provided at that time. Such biopsies are not considered components of other procedures when performed on different lesions or different sites on the same date, and are to be reported separately.

Based on the submitted documentation it does not appear the biopsy (shave technique) procedures (11100 and 11101) were distinct or separate from the other integumentary procedures performed on the same day (17004 and 17311).

The additional reimbursement of \$75.50 is warranted per the OMFS Outpatient Hospital and Ambulatory Surgery Center Fee Schedule code 17106 (17999). There is no additional reimbursement warranted per the OMFS Outpatient Hospital and Ambulatory Surgery Center 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 Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
17106 (17999)	1	\$2,487.65	\$87.85	\$12.35	\$75.50	OMFS
11100	1	\$150.00	\$0.00	\$0.00	\$0.00	OMFS
11101	3	\$225.00	\$0.00	\$0.00	\$0.00	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 code 17106 (\$75.50) for a total of \$410.50.

The Claims Administrator is required to reimburse the provider \$410.50 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,

██████████, RHIT

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

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