

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

6/11/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000781	Date of Injury:	12/03/2012
Claim Number:	[REDACTED]	Application Received:	11/22/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/31/2013 – 07/31/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	11100 - 59		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 01/29/2014, 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: Official Medical Fee Schedule-Hospital Outpatient Departments and Ambulatory Surgical Centers

Supporting Analysis:

The dispute is regarding the denial of payment for surgical procedure code 11100 modifier 59 for date of service 07/31/2013. The Claims Administrator denied the payment in the amount of \$250.00 with the explanation "Service exceeds pre-authorized approval. Please provide documentation and/or additional authorization for the service not included in the original authorization".

The Independent Bill Review (IBR) case was forwarded to the Division of Workers' Compensation (DWC) for an eligibility review. The DWC deemed the case eligible for the IBR process.

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

Modifier 59 - Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

The Provider is considered ambulatory surgical center (ASC) and is located in Los Angeles County. The Provider submitted documentation for a skin biopsy operative report. Authorization submitted by the provider was incomplete (missing pages) with a date requested for 04/03/2013 and a date completed for 04/05/2013. The first page referenced an attached "Certification Recommendation letter dated 02/28/2013"; Certification letter was missing. MAXIMUS requested a complete copy of the Authorization letter for the disputed service performed on 7/31/2013. The Provider did not submit any additional documents. The Claims Administrator submitted a Certification Recommendation with a determination date 05/14/2013, a request for authorization date 05/06/2013, and validity dates 05/14/2013 to 07/14/2013. The Certification Recommendation letter submitted by the Claims Administrator listed the following services as certified from 5/14/2013 to 7/14/2013: Mohs surgery; skin repair; and fractionated laser. Based on documentation submitted by the Provider and Claims Administrator it does not appear the service was authorized for the date of service 07/31/2013.

Based on review of explanation of review (EOR) and treatment authorization letter, the denial by the Claims Administrator was correct.

There is no additional reimbursement warranted per the Official Medical Fee Schedule code 11100 modifier 59.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
11100	1	\$250.00	\$0.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on explanation of review (EOR) and treatment authorization letter and comparison with Official Medical Fee Schedule-Hospital Outpatient Departments and Ambulatory Surgical Centers. 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)

[REDACTED]

[REDACTED]

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

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