

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**Independent Bill Review Final Determination Upheld**

9/29/2014

████████████████████  
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IBR Case Number:	CB13-0000848	Date of Injury:	12/08/1980
Claim Number:	████████████████	Application Received:	12/11/2013
Claims Administrator:	██		
Date(s) of service:	7/17/2013 – 7/17/2013		
Provider Name:	██		
Employee Name:	██		
Disputed Codes:	11100 and 11101		

Dear ████████████████████:

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 4/2/2014, 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: Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS, NCCI Version 19.2 (7/1/2013 - 9/30/2013))

### Supporting Analysis:

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 dispute regards the payment for surgical facility services on date of service 7/17/2013. The facility services were billed on UB-04/CMS1450 using revenue codes for services and supplies related to CPT 17004, CPT 11100, and CPT 11101.

The Provider is disputing the payment amount of \$0.00 for CPT codes 11100 and 11101. The initial and final explanation of review did not result in reimbursement for CPT 11100 and 11101.

2013 AMA Current Procedural Terminology (CPT) definitions for the CPT codes in question are as follows:

- **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 11100 was denied with the following explanation/reason codes:

- **G7** No separate payment was made because the value of the service is included within the value of another service performed the same day (11100, 17004).
- **898** In accordance to clinical based Coding edits (National Correct Coding Initiative/Outpatient Code Editor), Component code of comprehensive surgery: Integumentary Procedure (10000-19999) has been disallowed.

CPT 11101 was denied with the following explanation/reason codes:

- **G10** We cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible. (Add-on code should be billed base code).
- **7069** This Procedure code is only reimbursed when billed with the appropriate initial base code

Documentation provided for this review consisted of two Operative Reports; 1) Operative Report indicated the cryosurgery (17004) - performed in the following areas: face, ears, and upper extremities. 2) Skin Biopsy Operative Report performed on the following areas: L. upper forehead; and R. lateral upper cheek. The operative reports for both procedures are ambiguous as to the specific anatomical site denoted to its prospective procedure; there is not an anatomical chart to clarify this question.

Guidelines indicate that CPT Code 11100 is identified as a code pair with the surgical CPT code 17004. CPT codes 11100 and 17004 may be billed together if supported by documentation and an appropriate modifier is appended. The submitted CMS UB-04 reflected the billed codes: 17004; 11100; and 11101 without any modifiers. In this case, modifier 59 would be utilized to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.

CPT code 11101 is an add-on code to CPT 11100. Coding guidelines dictate add-on codes, if warranted, may be added to its parent code. In this IBR case, due to the absence of supportive documentation and the required modifier, the use of CPT 11101 is not indicated; reimbursement therefore, is not recommended.

Based on the aforementioned guidelines and discussion, additional reimbursement for the billed CPT codes 11100 and 11101 is not recommended.

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	\$250.00	\$0.00	\$0.00	\$0.00	OMFS
11101		1	\$75.00	\$0.00	\$0.00	\$0.00	OMFS

**Chief Coding Specialist Decision Rationale:**

This decision was based on supplied medical record and comparison with OMFS Outpatient Hospital and Ambulatory Surgery Center. 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  
Chief Coding Reviewer

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