INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 26, 2015

Dear [Name],

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $250.00 for the review cost and $3514.38 in additional reimbursement for a total of $3764.38. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $3764.38 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc:
DOCSUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- 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
- Negotiated contracted rates: PPO Discount 5%
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- ISSUE IN DISPUTE: Provider is dissatisfied with reimbursement of code 26145. Provider billed for 9 units and was reimbursed for only 3 units.
- Claims administrator reimbursed $1881.21 indicating on the Explanation of Review “The number of units billed exceeds the threshold amount that has been determined for this procedure or service.”
- Based on review of the operative report, provider documents “A copious amount of hypertrophic tenosynovium was then noted on the nine flexor tendons in the palm and a careful and sharp tensynovectomy of the nine tendons in the palm was then performed.”
- The provider is considered an ambulatory surgical center (ASC). 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 26145 has 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
- The CPT codes from the original UB-04/CMS1450 claim form were entered into the Outpatient Prospective Payment System Calculator. The payment was calculated for CPT
26145, subject to the multiple procedure reduction of 50% and based on the number of units billed. The Provider billed for a total of nine units for CPT 26145. Per a review of the operative report, tenosynovectomy of nine tendons was performed.

- Based on information reviewed, additional reimbursement of code 26145 is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of code 26145 is recommended.

<table>
<thead>
<tr>
<th>Date of Service: 6/13/2014</th>
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<tbody>
<tr>
<td><strong>Service Code</strong></td>
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<tr>
<td>-------------------</td>
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<tr>
<td>26145 x 9</td>
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Copy to:

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