Dear [Redacted]:

**Determination:**
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 01/24/2014, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of $335.00 and the amount found owing of $1,363.00, for a total of $1,698.00.

**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: Official Medical Fee Schedule-Hospital Outpatient Departments and Ambulatory Surgical Centers

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**Independent Bill Review Final Determination Reversed**

6/11/2014

**IBR Case Number:** CB13-0000984  **Date of Injury:** 05/06/2013

**Claim Number:** [Redacted]  **Application Received:** 12/27/2013

**Claims Administrator:** [Redacted]

**Date(s) of service:** 08/15/2013 – 08/15/2013

**Provider Name:** [Redacted]

**Employee Name:** [Redacted]

**Disputed Codes:** 26370, 26373, 26373, 20103, 29126
Supporting Analysis:
The dispute regards the payment for surgical facility services on date of service 08/15/2013. The facility services were billed on a UB-04/CMS 1450 using revenue codes for services and supplies related to CPT 26370, 26373, 26373, 20103, and CPT 29126. The Provider was reimbursed $2,459.59 for the billed surgical codes 26370 and 26373, and is requesting additional reimbursement of $11,099.46. The Claims Administrator denied the CPT codes 26373 Modifier 51 and 20103 with the explanation “The charge was denied as the report/documentation does not indicate that the service was performed”. The Claims Administrator denied CPT code 29126 with the explanation “This service is included in primary or more extensive procedure”.

CPT 26370 - Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon
CPT 26373 – Repair or advancement of profundus tendon, with intact superficialis tendon; secondary without free graft, each tendon
CPT 20103 – Exploration of penetrating wound (separate procedure); extremity
CPT 29126 - Application of short arm splint (forearm to hand); dynamic
Modifier 51 – Multiple Procedures

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 provider is considered an ambulatory surgical center (ASC) and is located in Los Angeles County. 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 surgical CPT 26370, 26373, and 26373 billed have an assigned indicator of “T”. The “T” indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. The surgical CPT 29126 billed has an assigned indicator of “S”. The “S” indicator definition is “Significant Procedure, Not Discounted When Multiple. Paid under OPPS; separate APC payment”.

The operative report documented the following procedures on the left hand: Left hand ring finger flexor digitorum profundus repair (primary repair); Left hand ring finger flexor digitorum profundus release of adhesions; Left hand ring finger digitorum superficialis release of adhesions; Left hand volar exploration of previous traumatic wound; Left hand volar release of scar tissue; Left hand application of a dynamic blocking splint to the ring finger.

The billed procedure codes CPT code 26370 is a primary repair or advancement of profundus tendon, with intact superficialis tendon for each tendon. The CPT codes 26373 and 26373 are secondary repairs or advancement of profundus tendon, with intact superficialis tendon; secondary
without free graft for each tendon. The operative report did indicate that a primary repair of the profundus tendon and two secondary repairs of the profundus tendon were performed. Per the operative report “The integrity of the flexor digitorum superficialis repair was confirmed; I decided to perform my flexor digitorum profundus repair first by passing; I had exiting the ends of the tendon to each other creating an end-to-end repair of the flexor digitorum profundus”. The Claims Administrator denial of documentation not indicating the service was performed for the second billed CPT code 26373 Modifier 51 was not correct.

CPT code 20103 exploration of penetrating wound (separate procedure); extremity
When this code is referenced in the musculoskeletal section, it describes an exploration of a penetrating wound of the extremity which is defined as a procedure or service commonly performed as an integral component of a total service or procedure. As such, this procedure should not be reported in addition to the code for a total procedure or service. The repair codes 26370 and 26373 include the exploration of the wound; therefore, CPT 20103 does not warranted separate reimbursement. The operative report did not indicate an exploration of a penetrating wound of an extremity (separate procedure): separate or independent of the primary repair code 26370. Therefore, the denial of reimbursement for the billed CPT 20103 by the Claims Administrator was correct.

The CPT code 29126 application of short arm splint (forearm to hand); dynamic should not be reported separately from the CPT code 26370 and code 26373. CPT Assistant Archives (4th Quarter 1990 - present) Casting - Strapping - Splinting: For Hospital Outpatient Reporting (April 2002) page 13 says "Codes 20900-29799 are not used to report: an initial cast/strapping service when the restorative treatment is performed (e.g., surgical repair, closed or open reduction of a fracture or joint dislocation)". The codes 29000-29799 are used to report: replacement casting/strapping during follow-up; initial casting/strapping when no other treatment or procedure (specific to the injury) is performed; and an initial service performed without restorative treatment and/procedures to protect a fracture, injury or dislocation, and/or pain relief to a patient. The initial casting procedure is inclusive of the surgical repair codes 26370 and 26373 performed during the same encounter; Therefore, the denial of reimbursement for the billed CPT 29126 by the Claims Administrator was correct.

Based on a review of the explanation of review (EOR) and coding guidelines, the reimbursement by the Claims Administrator was made according to the OMFS Outpatient Hospital and Ambulatory Surgical Center Fee Schedule. The reimbursement amount was calculated based on multiple surgery guidelines. Based on the multiple surgery guidelines, reimbursement should have been based on the following: Primary code 26373 100% of listed value; and all other allowed procedures (26370 and 26373 Modifier 51) considered at 50% of listed value.

The surgical procedure code 26373 was considered at 100% of OMFS allowance. The reimbursement of CPT 26370 should have been based on the multiple surgery reduction guidelines, 50% of the OMFS allowance. The reimbursement of CPT 26370 was $548.30. The OMFS Outpatient Hospital allowance for CPT 26370 with the multiple surgery reduction of 50% is $955.65. The reimbursement of the second CPT 26373 was $0.00. The OMFS Outpatient Hospital allowance for CPT 26373 with the multiple surgery reduction of 50% is $955.65.

The additional reimbursement of $1,363.00 is warranted per the Official Medical Fee Schedule for the surgical facility services on date of service 8/15/2013.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.
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 26370 and 26373 ($1,363.00) for a total of $1,698.00.

The Claims Administrator is required to reimburse the provider $1,698.00 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).