Dear Precision Surgicenter:

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 reversed. The Claims Administrator is required to reimburse you the IBR fee of $335.00 and the amount found owing of $5,940.67, for a total of $6,275.67.

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: Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS), NCCI Edits, American Medical Association Current Procedural Code Book
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 coding guidelines, the hospital outpatient prospective payment system (OPPS), and the OMFS Fee Schedule 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 10/30/2013. The facility services were billed on UB-04/CMS1450 using revenue codes for services and supplies related to CPT Codes 64721 and 26145 (9 Units).

The Claims Administrator reimbursed $748.77 for CPT 64721 and provided the following explanation/reason codes:

- **G1** The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.
- **790** Workers’ Compensation State fee schedule adjustment. Labor Code 5307.1

The Claims Administrator reimbursed $748.77 for CPT 26145 and provided the following explanation/reason codes:

- **F4** Service not paid under outpatient facility fee schedule
- **496** Allowance for this service is made at 50% of the surgery fee as per the OPPS multiple procedure rule. Labor code 5307.1.

The provider is disputing non-reimbursement for CPT Code 26145 (9 Units).

2013 AMA CPT code descriptions are as follows:

- **CPT 64721**: Neuroplasty and/or transposition; median nerve at carpal tunnel
- **CPT 26145**: Synovectomy tendon sheath, radical (tenosynovectomy), flexor, palm or finger, single, each digit.

Per the Operative Report, Procedures Performed, Date of Service 10/30/2013, “Left carpal tunnel release with tenosynovectomy of the flexor tendons in the palm”.

Upon Review of the Operative Report provided, the surgeon states, “A copious amount of hypertrophic tenosynovium was then noted on the nine flexor tendons in the palm and a careful and sharp tenosynovectomy of the nine tendons in the palm was then performed.” This statement clearly defines and supports nine units of CPT code 26145; therefore, it is recommended the provider be reimbursed accordingly.
The Provider is considered an ambulatory surgical center (ASC) and is located in Alameda County. Based on the provider type, the reimbursement for the 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 code 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 carpal tunnel release (64721, Neuroplasty and/or transposition; median nerve at carpal tunnel) and the tenosynovectomy (26145, Synovectomy, tendon sheath, radical [tenosynovectomy], flexor tendon, palm and/or finger, each tendon) can be billed together as there are no Correct Coding Initiative (CCI) edits that restrict the pairing.

A contractual agreement between the Provider and Claims Administrator has yet to be received for this IBR. Since there is no contractual agreement to govern this decision, IBR must then abide by the CMS guidelines for all coding constructs; as stated in “Title 8” in the opening of this analysis. Therefore, in reviewing the documentation and coding guidelines, in absence of a contractual agreement between Provider and Claims Administrator, reimbursement is warranted for the primary code 64721 (100% listed value) and the secondary procedures billed as 26145 x 9 units (50% of listed value).

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

<table>
<thead>
<tr>
<th>Validated Code</th>
<th>Validated Units</th>
<th>Dispute Amount</th>
<th>Total Fee Schedule Allowance</th>
<th>Provider Paid Amount</th>
<th>Allowed Recommended Reimbursement</th>
<th>Fee Schedule Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>64721</td>
<td>1</td>
<td>$748.77</td>
<td>$1,497.53</td>
<td>$748.77</td>
<td>$748.76</td>
<td>OMFS</td>
</tr>
<tr>
<td>26145</td>
<td>9</td>
<td>$5,191.95</td>
<td>$5,940.68</td>
<td>$748.77</td>
<td>$5,191.91</td>
<td>OMFS</td>
</tr>
</tbody>
</table>

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 64721 and 26145 ($5,940.67) for a total of $6,275.67.

_The Claims Administrator is required to reimburse the provider $6,275.67 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,

[Signature], RHIT
Chief Coding Reviewer

IBR Final Determination Reversed
Form Effective 7.22.2013