

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

11/18/2013

Independent Bill Review Final Determination Reversed

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 5/29/2013 – 5/29/2013
MAXIMUS IBR Case: CB13-0000322

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/26/2013, 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 \$3,762.51, for a total of \$4,097.51.**

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: PPO Contract
- Other: Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 5/29/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 64721 and CPT 26145 (9 units). The Provider was reimbursed \$3,303.86, and is requesting additional reimbursement of \$3,761.98 for CPT 26145. The Claims Administrator allowed reimbursement for CPT 64721 and reimbursed three units of CPT 26145 indicating "This charge was adjusted to comply with the rate and rules of the contract indicated."

CPT 64721 - Neuroplasty and/or transposition; median nerve at carpal tunnel.

CPT 26145 - Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon.

The provider is considered an ambulatory surgical center (ASC) and is located in Alameda 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 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.

The additional reimbursement of \$3,762.51 for Official Medical Fee Schedule code 26145 is warranted based on the submitted documentation.

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

Validated Code	Validated Modifier	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
26145			9	\$3,761.89	\$5,643.72	\$1,881.21	\$3,762.51	PPO Contract

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 26145 (\$3,762.51) for a total of \$4,097.51.

The Claims Administrator is required to reimburse the provider \$4,097.51 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,

[REDACTED], RHIT

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

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