

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280

Independent Bill Review Final Determination Reversed

12/20/2013

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 3/27/2013 – 3/27/2013
MAXIMUS IBR Case: CB13-0000361

Dear [REDACTED],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/5/2013, 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 \$6,927.10, for a total of \$7,262.10.**

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 3/27/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 24341 and CPT 64718. The Provider was reimbursed \$2,951.10, and is requesting additional reimbursement of \$8,135.38. The Claims Administrator allowed reimbursement for CPT 24341 and 64718 indicating "This charge was adjusted to comply with the rate and rules of the contract indicated."

CPT 24341 - Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff).

CPT 64718 - Neuroplasty and/or transposition; ulnar nerve at elbow.

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 (HOPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (HOPPS) 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 (HOPPS), CMS coding guidelines and the hospital outpatient prospective payment system (HOPPS) was referenced during the review of this Independent Bill Review (IBR) case.

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 24341 and 64718 has an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment.

The CPT codes from the original UB-04/CMS1450 claim form were entered into the Outpatient Prospective Payment System Calculator. The payment was calculated based on multiple surgery guidelines, the primary procedure 24341(1 unit) was considered at 100% of the PPO allowance and the remaining four units of 24341 were considered at 50% of the PPO allowance. The operative report documented the repair of five tendons :pronator teres; palmaris longus; flexor digitorum superficialis, flexor carpi radialis, and flexor carpi ulnaris tendons. The reimbursement of only one unit of CPT 24341 by the Claims Administrator was not correct.

Based on a review of the multiple surgery guidelines and the National Correct Coding Initiative/Outpatient Code Editor Version 19.0 (1/1/2013-3/31/2013), the billed procedure code 64718 is not generally reported with procedure code 24341. NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances. The procedure code 64718 is incidental to the primary procedure code 24341. The documentation did not indicate that the procedure 64718 was distinct or independent from other service (24341) performed that day. These two procedures are not reported together when performed on the same site (left upper extremity) during the same patient encounter. The operative report did not indicate a different session or patient encounter, different procedure or surgery, different site.

The additional reimbursement of \$6,927.10 for the surgical facility services for date of service 3/27/2013 is warranted.

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 Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
24341, 64718		5	\$8,135.38	\$9,878.20	\$2,951.10	\$6,927.10	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 Ambulatory Surgical Center Fees (\$6,927.10) for a total of \$7,262.10.

The Claims Administrator is required to reimburse the provider \$7,262.10 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,

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