

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

Fax: (916) 605-4280

---

**Independent Bill Review Final Determination Reversed**

1/15/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 5/19/2013 – 5/19/2013  
MAXIMUS IBR Case: CB13-0000401

Dear [REDACTED],

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/20/2013, 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 \$891.39, for a total of \$1,226.39.**

**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: OMFS Outpatient Hospital Fee Schedule, National Correct Coding Initiative/Outpatient Code Editor Version 19.1 (4/1/2013-6/30/2013)

## **Supporting Analysis:**

The dispute regards the payment for surgical facility services on date of service 5/19/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 25020 and CPT 64721. The Provider was reimbursed \$1,255.06, and is requesting additional reimbursement of \$1,587.87. The Claims Administrator allowed reimbursement of \$1,245.96 for CPT 64721 indicating "The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance." The Claims Administrator denied reimbursement on CPT 25020 with the explanation "Included in 64721 per AAOS guidelines."

The Provider is disputing the denial of the billed procedure code 25020.

CPT 25020 - Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; without debridement of nonviable muscle and/or nerve.

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

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 Orange 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 25020 and 64721 have 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 25020 (1 unit) was considered at 100% of the OMFS allowance and the billed CPT 64721 was considered incidental to the primary code. The operative report documented a right carpal tunnel release and decompressive fasciotomy of the distal forearm and wrist fascia. The reimbursement of the billed CPT 64721 at 100% and denial of CPT 25020 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 19.1 (4/1/2013-6/30/2013), the billed procedure code 64721 is not generally reported with procedure code 25020. The service described by CPT 64721 is typically included when performing the procedure described by CPT 25020 and is therefore bundled into CPT code 25020. The documentation did not indicate that the procedure code 64721 was

