

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

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Independent Bill Review Final Determination Upheld

1/15/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 6/3/2013 – 6/3/2013
MAXIMUS IBR Case: CB13-0000406

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 upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

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
- 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 6/3/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 25020, CPT 20605 and CPT 64721. The Provider was reimbursed \$2,455.50, and is requesting additional reimbursement of \$736.13. The Claims Administrator allowed reimbursement of \$2,137.35 for CPT 25020. The Claims Administrator reimbursed 169.20 for CPT 20605. The Claims Administrator denied reimbursement on CPT 64721 with the explanation "No additional reimbursement allowed after review of appeal/reconsideration/request for second review."

The Provider is disputing the denial of the billed procedure code 64721 and reimbursement amount of 20605.

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.

CPT 20605 - Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa).

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, 20605 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 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 release of left carpal tunnel with release of the distal forearm and wrist fascia. The reimbursement of the billed CPT 25020 at 100% and denial of CPT 64721 by the Claims Administrator was 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 distinct or independent from the other service procedure code 25020 performed that day. These two procedures are not reported together when performed on the same site during the same patient encounter. The operative report did not indicate a different session or patient encounter, different procedure or surgery, different site.

Based on a review of the explanation of review, the Claims Administrator reimbursed the provider \$169.20 for the billed procedure code 20605. The allowance is correct based on the number of units billed, multiple surgery guidelines and the OMFS Outpatient Hospital and Ambulatory Surgery Center Fee schedule. The primary procedure CPT 25020 (100%) and the second procedure CPT 20605 (50%).

There is no additional reimbursement warranted for the Official Medical Fee Schedule codes 64721 and 20605.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates 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
ASC Services		1	\$736.13	\$2,455.50	\$2,455.50	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Outpatient Hospital Fee Schedule, National Correct Coding Initiative/Outpatient Code Editor and comparison with explanation of review. This was determined correctly by the Claims Administrator and the payment of \$2,455.50 is upheld.

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,

██████████, RHIT

Copy to:

██████████
 ██████████
 ██████████

Copy to:

[Redacted]