

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**Independent Bill Review Final Determination Upheld**

6/11/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB13-0000515	Date of Injury:	9/30/2012
Claim Number:	[REDACTED]	Application Received:	9/25/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	4/20/2013 – 4/20/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	25020 and 64727		

Dear [REDACTED]:

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/23/2013, 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 Surgery Guidelines and Ground Rules

**Supporting Analysis:**

The dispute regards the payment for surgical facility services on date of service 4/20/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 25020, 64727 and CPT 64721. The Claims Administrator reimbursed of \$1,245.96 for CPT 64721 with the explanation "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 another procedure." The Claims Administrator denied reimbursement on CPT 64727 with the explanation "services unsubstantiated by documentation."

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 64727 – Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)

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.

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, 64721 and 64727 have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment.

The Claims Administrator denied the billed procedure code 64727 due to "services unsubstantiated by documentation." The use of the procedure code 64727 requires the use of an operating microscope. Per the Operative report, "Complete release was performed under direct visualization using tenotomy scissors. The median nerve was visualized and superficial neurolysis was performed." The Operative Report did not document the use of an operating microscope during the neurolysis procedure. The denial of procedure code 64727 by the Claims Administrator was correct.

The Claims Administrator denied the billed procedure code 25020 due to "Included in another procedure." The Claims Administrator submitted additional documentation supporting their decision to deny the billed procedure code 25020. The Claims Administrator's stated rationale was "decompressive fasciotomy of the distal forearm and wrist for the purpose of decompressing the median nerve is reported as 64721 according to the AMA CPT and AAOS guidelines. The surgical report did not indicate that either a flexor or extensor compartment decompression was rendered. Therefore, no allowance was recommended as 25020 is part of a carpal tunnel release or transposition procedure (64721)."

The operative report documented the following: diagnosis “right carpal tunnel syndrome”; and patient “presents for a right carpal tunnel release.” The procedure was documented as “A midline incision was made directly over the wrist. Palmar fascia was incised in line with the skin incision. The underlying transverse carpal ligament was visualized and incised sharply using a #15 blade. Complete release was performed under direct visualization using tenotomy scissors. We again performed decompressive fasciotomy of the distal forearm and wrist fascia decompressing the median nerve approximately to the wrist.” The decompression procedure documented in the Operative Report is included in the carpal tunnel decompression procedure, billed as CPT 64721. The carpal tunnel release procedure (64721) is decompression or freeing of an intact nerve. The procedure code 25020 is a more extensive procedure used to report a decompressive fasciotomy of the forearm for compartment syndrome. A thorough coding review was conducted based on the documentation submitted. The documentation submitted did not support the reimbursement and code assignment of CPT 25020. The denial of the billed procedure code 25020 by the Claims Administrator was correct.

There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 25020 and 64721.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
25020	1	\$5,670.30	\$0.00	\$0.00	\$0.00	OMFS
64727	1	\$3,304.20	\$0.00	\$0.00	\$0.00	OMFS

**Chief Coding Specialist Decision Rationale:**

This decision was based on OMFS Outpatient Hospital Fee Schedule, medical record and comparison with explanation or review (EOR). This was determined correctly by the Claims Administrator and the payment of \$0.00 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)

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