

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

7/2/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000517	Date of Injury:	3/21/2013
Claim Number:	[REDACTED]	Application Received:	9/25/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	7/1/2013 – 7/1/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	64721		

[REDACTED]
[REDACTED]

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/14/2014, 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 Version 19.2 (7/1/2013-9/30/2013)

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 7/1/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 25020 and CPT 64721 Modifier 51. The Provider was reimbursed \$2,410.69, and is requesting additional reimbursement of \$3,304.20. The Claims Administrator allowed reimbursement of \$2,137.35 for CPT 25020 and an additional \$273.34 for CPT 20605, 81025 and other miscellaneous supplies and/or services. The Claims Administrator denied reimbursement on CPT 64721 with the explanation "The charge was adjusted to comply with the rate and rules of the contract indicated."

The Provider is disputing the bundling of the denial of CPT 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.
- **Modifier 51:** Multiple Procedures

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 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 operative report documented a release of right carpal tunnel with release of distal forearm and wrist fascia.

Based on a review of the multiple surgery guidelines and the National Correct Coding Initiative Version 19.2 (7/1/2013-9/30/2013), the service described by CPT 64721 are typically included in 25020. All services necessary to complete a procedure based upon standard medical/surgical practice are included in the procedure. The service described by CPT code 64721 is typically included when performing the procedure described by CPT code 25020 and is therefore bundled into CPT code 25020. The Operative Report did not indicate a different session or patient encounter, different procedure or surgery, different site; therefore, additional reimbursement for the billed procedure code 64721 is not warranted.

There is no additional reimbursement warranted per the Official Medical Fee Schedule for the surgical facility service code 64721 performed on date of service 7/1/2013.

