

**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**

10/8/2014

██████████  
████████████████████  
██████████

IBR Case Number:	CB13-0000767	Date of Injury:	11/15/2005
Claim Number:	██████████	Application Received:	11/20/2013
Claims Administrator:	██████████		
Date(s) of service:	05/29/2013 – 05/29/2013		
Provider Name:	████████████████████		
Employee Name:	██████████		
Disputed Codes:	26145-LT x 9 Units		

Dear ██████████

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 04/18/14, 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 **\$2616.30** for a total of **\$2951.30**

**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

**ANALYSIS AND FINDING**

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Code 26145-LT x 9 units is under review as it was denied in full (or part) for SERVICE. Denied by Claims Administrator with the following explanations:**
  - i. *The Value of this procedure is included in the value of another procedure performed on this date.*
    - I. *Included in Code 64721 Neuroplasty and/or transposition; median nerve at carpal tunnel*
  - ii. *Allowance is based on utilization review pre-authorization.*
  - iii. *The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.*
  - iv. *Workers’ Compensation state fee schedule adjustment.*
- *\*Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers’ Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers’ Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.*
- CPT 26145: Synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, **each tendon.**
  - i. Operative Report Documentation, “It was found to have evidence of longstanding compression including an hourglass shape and hyperemia. A copious amount of hypertrophic tenosynovium was then noted on the nine flexor tendons in the palm and a careful and sharp tenosynovectomy of the nine tendons in the palm was then performed.”
    - I. Separate Procedure from 64721, Operative Report Documentation, “The median nerve was then gently dissected from the surrounding adhesions.” Because ‘copious amount of hypertrophic tenosynovium,’ was ‘noted,’ 26145 was then performed.

Based on the OMFS Guidelines, 26145 x 9 Units is warranted and reimbursement is recommended.

- $R\text{VU } 5.00 \times \text{CF } \$153.00 \times 5\% \text{ OMFS} = \$726.75 \text{ per Units} \times 9 \text{ Units} \times \text{Mod } 59. = \$3270.38 - \text{Reimbursed Amount } \$654.08 = \mathbf{\$2616.30.}$
- **DETERMINATION OF ISSUE IN DISPUTE: Allow reimbursement of code 26145-LT x 9 units as service was separate and distinct from code 64721 and there are no coding \*guidelines which state codes are a bundled pair and may not be separately reported.**

Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amount	Notes
<i>Date of Service – 05/29/2013</i>						
<i>Outpatient Surgery</i>						
26145-LT	\$14,770.00	\$654.08	\$13,032.00	9	\$3,270.38	Refer to Analysis
64721	\$	\$			Not in Dispute	Service not in dispute

**Determination: Reversed**

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 CPT code 26145-LT x 9 Units, (**\$2616.30**) for a total of **\$2951.30**

The Claims Administrator is required to reimburse the provider **\$2951.30** 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,

██████████, RHIT  
Chief Coding Review

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