

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**Independent Bill Review Final Determination Reversed**

4/28/2014

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 7/22/2013 – 7/22/2013  
MAXIMUS IBR Case: CB13-0000663

Dear [REDACTED]

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 11/26/2013, 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 \$1,822.40, for a total of \$2,157.40.**

**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: PPO Contract
- Other: OMFS Outpatient Hospital Fee Schedule, National Correct Coding Initiative/Outpatient Code Editor Version 19.2 (7/1/2013-9/30/2013)

**Supporting Analysis:**

The dispute regards the payment amount for outpatient hospital services performed on 7/22/2013. The outpatient hospital services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29846 and CPT 64721. The Claims Administrator reimbursed \$1,702.70 for the billed procedure code 64721 with the explanation "This charge was adjusted to comply with the rate and the rules of the contract indicated." The Claims Administrator denied reimbursement on CPT 29846 with the explanation "No payment is being made, as none is necessarily owed."

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

CPT 29846 - Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement

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, and 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 29846 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 left wrist arthroscopic debridement of the scapholunate ligament, left wrist arthroscopic debridement of the triangular complex (TFCC), and left wrist arthroscopic limited synovectomy; and left wrist release of the median nerve at the carpal tunnel.

The billed procedure codes 29846 and 64721 can be reported together and qualify for separate APC payment. The procedure code 29846 is considered the major procedure (highest APC weight) and reimbursable at 100% of the listed rate. The second billed procedure 64721 is reimbursable at 50% of the listed rate.

The additional reimbursement of \$1,822.40 is warranted per the Official Medical Fee Schedule Hospital Outpatient procedure codes 29846 and 64721.

