

**MAXIMUS FEDERAL SERVICES, INC.**

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

7/21/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-0000131	Date of Injury:	3/19/2013
Claim Number:	[REDACTED]	Application Received:	1/31/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	5/31/2013 – 5/31/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	24341		

Dear [REDACTED]:

**Determination**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/24/2014, 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: Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

### **Supporting Analysis:**

The dispute regards the payment for surgical facility services on date of service 5/31/2013. The facility services were billed on UB-04/CMS1450 using revenue codes for services and supplies related to CPT codes: 64708, 25290, 24102, 26442 and 24341. The Claims Administrator reimbursed \$5,587.81 for the following billed procedure codes: 64708, 25290, 24102 and 26442. The Claims Administrator denied the billed procedure code 24341 with the explanation "Per CCI edits, the value of this procedure is included in the value of the comprehensive procedure."

- **CPT 64708:** Neuroplasty, major peripheral nerve, arm or leg, open; other than specified
- **CPT 25290:** Tenotomy, open, flexor or extensor tendon, forearm and/or wrist, single, each tendon
- **CPT 24102:** Arthrotomy, elbow; with synovectomy
- **CPT 26442:** Tenolysis, flexor tendon; palm AND finger, each tendon
- **CPT 24341:** Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary (excludes rotator cuff)

The Provider is disputing the denial of the billed procedure code 24341 x 6 units.

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.

The Operative Report documented the following postoperative diagnoses: right radial tunnel syndrome, right lateral epicondylitis with synovitis of the radiocapitellar joint, and right third digit stenosing tenosynovitis; and procedures: right radial tunnel release with sectioning of the proximal and distal edges of the supinator muscle and the leading edge of the extensor carpi radialis brevis tendon, lateral epicondyle debridement with reattachment of the extensor tendons and synovectomy of the radiocapitellar joint, excision of right third digit A1 pulley with tenolysis of the flexor tendons.

The CPT codes corresponding to more extensive procedures always include the CPT codes corresponding to less complex procedures. The CPT code 24102 is a more extensive procedure that includes CPT code 24341. Accordingly, only the more extensive procedure, CPT code 24102 should be reported. The CPT code 24341 is bundled into CPT code 24102. The open synovectomy procedure (24102) includes the incision and/or repair of muscle/tendon (24341) in order to access the joint and remove synovium. Reimbursement for the billed CPT code 24341 is not recommended.

There is no additional reimbursement warranted per the surgical facility services, billed procedure code 24341 for the date of service 5/31/2013.

