

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

8/22/2014

██████████
██████████
██████████

IBR Case Number:	CB14-0000252	Date of Injury:	3/23/2005
Claim Number:	██████████	Application Received:	2/24/2014
Claims Administrator:	██████████		
Date(s) of service:	7/16/2013		
Provider Name:	██████████		
Employee Name:	██████████		
Disputed Codes:	64719 51		

Dear ██████████

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/25/2014 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount \$256.40 found owing a total of \$591.40.**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:

The following evidence were utilized to support this 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
- Other: OMFS Physician Services Fee Schedule, Surgery General Information and Ground Rules.

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 7/16/2013. The facility services were billed on UB-04/CMS1450 using revenue codes for services and supplies related to CPT 64721, 64719 51, and 20550. The Claims Administrator reimbursed \$0.00 for the following billed procedure code(s): 64719 51 and 20550. The Claims Administrator denied the billed procedure codes with the explanation "No separate payment was made because the value of the service is included within the value of another service performed on the same day." ***This Provider is disputing the denial of CPT 64719 51.***

The American Medical Association Current Procedural Terminology 1997 defines the relevant CPT Codes as follows:

CPT 64721 R: Neuroplasty and/or transposition; cranial nerve (specify); median nerve at carpal tunnel.

CPT 64719 51: Neuroplasty and/or transposition; cranial nerve (specify); ulnar nerve at wrist.

MODIFIER 51: Multiple Procedures - When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see Appendix D).

The Preoperative procedure description for Date of Service 7/16/2013, states "Carpal tunnel release, right wrist; Release of Guyon's canal, right hand; Injection of dexamethasone, left elbow epicondyle." Under "Procedure in Detail," the surgeon documented, "skin and subcutaneous tissues were bluntly and sharply dissected to expose the transverse carpal ligament, the **volar carpal ligament** and **Guyon's canal**, using meticulous dissection... **All these structures** were divided with sharp dissecting and curved Mayo scissors."

The American Academy of Orthopedic Surgeons, CPT code 64721, Intraoperative services NOT included in the global service package: "neuroplasty of ulnar nerve for documented ulnar neuropathy". And, CPT code 64719, Intraoperative services NOT included in the global service package: "concomitant carpal tunnel release for documented median neuropathy".

It is noted that the EOB reflects that the Provider appended Modifier 51 to CPT code 64719, indicating the services was a multiple procedure performed at the same session by the same provider. This procedure was clearly documented in the operative report under the heading "Procedural Findings," and was also referenced in this review. Since the primary CPT code is 64721 and the concurrent procedure is 64713 and is clearly supported in the documentation, additional reimbursement is warranted per the PPO contract based on the following calculation:

PPO Allowance of 64719 = \$256.40 OMFS
\$523.26 -2% PPO Discount = \$512.80
\$512.80 x 50% (Multiple Surgery Rule Reduction) = \$256.40
Previously Paid = \$0.00
Total additional reimbursement due = \$256.40

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

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
64719	51	1	\$550.80	\$256.40	\$0	\$256.40	PPO Contract

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 64719 Modifier 51 (**\$256.40**) for a total of **\$591.40**.

The Claims Administrator is required to reimburse the provider \$591.40 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,

██████████, MHA, BSN, CFE, CCS-P, CCS, CDC

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