

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 21, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001600	Date of Injury:	08/16/2013
Claim Number:	[REDACTED]	Application Received:	10/23/2014
Claims Administrator:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	26442-59-F1 (2units), 26442-59-F2, 26442-59-F3 and 26145 x 9		

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

[REDACTED]
Medical Director

cc: [REDACTED]
[REDACTED]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- 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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital and ASC Fee Schedule

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

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

- **ISSUE IN DISPUTE:** The reimbursement of CPT 26442 59-F1 (2units), 26442-59-F2 (2units), 26442-59-F3 (2units) and 26145 x 9.
- Based on the NCCI edits, there are no coding edits for the billed CPT 26145 and 64721.
- CPT code 26145 is defined as a radical tenosynovectomy and the operative report documentation does not substantiate this procedure. The patient had a carpal tunnel release which is assigned CPT code 64721. The AAOS guidelines for CPT code 64721 include tenosynovectomy of flexor tendons.
- The operative report did not indicate the tenosynovectomy of the flexor tendons was a separate and distinct procedure from the carpal tunnel release procedure.
- Claims Administrator reimbursed the Provider for one unit of 26145, no additional reimbursement recommended.
- The operative report did not substantiate the multiple units of service per digit. Excision of A1 pulley and Tenolysis performed on the flexor tendons of the left second, third and fourth digit.
- In review of the EOR, the Claims Administrator reimbursed the Provider for 1 unit for each billed CPT 26442 59-F1, 26442-59-F2 and 26442-59-F3, minus a PPO discount.
- Additional reimbursement is not recommended for the disputed codes.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 26442 59-F1, 26442-59-F2, 26442-59-F3 and 26145 x 9 is not warranted.

Date of Service: 5/7/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
26145 (9 units)	\$ 7425.90	\$ 748.76	\$5191.96	50%	\$ 0.00	DISPUTED SERVICE: See Analysis.
26442-59-F1 2units	\$ 2876.14	\$4000.00	\$1471.14	100%	\$1980.23	DISPUTED SERVICE: Provider was reimbursed based on OMFS, minus a PPO discount
26442-59-F2 2 units	\$2876.14	\$1980.23	\$320.69	100%	\$1980.23	DISPUTED SERVICE: Provider was reimbursed based on OMFS, minus a PPO discount
26442-59-F3 2 units	\$2876.14	\$1980.23	\$320.69	100%	\$1980.23	DISPUTED SERVICE: Provider was reimbursed based on OMFS, minus a PPO discount
64721	\$ 1871.92	\$ 748.77	\$ N/A	N/A	Not in Dispute	Service not in dispute

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