

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

6/18/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000807	Date of Injury:	11/30/1995
Claim Number:	[REDACTED]	Application Received:	12/2/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	5/24/2013 – 5/24/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	G0260 and G0260 Modifier 50		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 1/28/2014, 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 found owing of \$639.28, for a total of \$974.28.**

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: OMFS
- Other: OMFS Outpatient Hospital Fee Schedule

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 05/24/13. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to G0260 and G0260 Modifier 50 and Modifier 51. The Claims Administrator reimbursed \$304.70 for billed procedure code G0260 and G0260 Modifier 50 and Modifier 51 with an explanation "The fee schedule does not include a value for the procedure code billed. An allowance has been made which is based on charges for similar/comparable services".

G0260 - Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

20610 - Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)

Modifier 50- Bilateral Procedure, Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

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 surgical HCPCS code G0260 has an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. The surgical CPT code 27096 has an assigned indicator of "B". The B indicator definition is "May be paid by fiscal intermediaries/MACs when submitted on a different bill type" and is not paid under OPPS.

The Operative Report documented Bilateral SI Joint Injection with fluoroscopic guidance. The Provider billed the Bilateral SI Joint Injection with HCPCS code G0260. The G0260 code and 27096 codes are for use billing SI Joint Injections performed with radiologic guidance. The description of CPT 27096 is "Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed." SI Joint Injections performed without the use of radiologic guidance should be billed using the 20610 code for an Injection into a Major Joint. A review of the submitted facility bill and operative report indicates that the Provider correctly billed HCPCS code G0260 and G0260 50 for bilateral anesthetic injection to sacroiliac joint on separate lines.

A review of the Addendum AA, ASC Covered Surgical Procedures for CY 2013 does not list HCPCS code 27096, but it does list G0260. Addendum B for CY 2013 does not list an APC Relative weight

for procedure code 27096, at relative weight is listed for HCPCS G0260. Therefore, the Provider correctly used HCPCS code G0260 for billing an anesthetic injection to sacroiliac joint and reimbursement is warranted for the ASC payment rate for HCPCS G0260 and G0260 Modifier 50.

Reimbursement for the billed bilateral SI Joint injection was based on the bilateral allowance of 150% of the fee schedule amount for a single code.

The additional reimbursement of \$639.28 is warranted per the Original Medical Fee Schedule (OMFS) Outpatient Hospital and Ambulatory Surgery Center Fee schedule code G0260 and G0260 Modifier 50.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date 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
G0260	50	2	\$575.47	\$943.98	\$304.70	\$639.28	OMFS

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 G0260 Modifier 50 (\$639.28) for a total of \$974.28.

The Claims Administrator is required to reimburse the provider \$974.28 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,

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