

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

February 2, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB14-0001717	Date of Injury:	07/10/2000
Claim Number:	[Redacted]	Application Received:	11/17/2014
Claims Administrator:	[Redacted]		
Date(s) of service:	02/27/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	G0260, G0260-50-51		

Dear [Redacted]

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: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$250.00 for the review cost and \$443.45 in additional reimbursement for a total of \$693.45. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$693.45 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. 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
- Negotiated contracted rates: PPO Discount of 5%
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

## 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:** Provider is dissatisfied with reimbursement of codes G0260 and G0260-50-51.
- Claims administrator reimbursed a partial payment indicating on the Explanation of Review “The procedure code billed does not accurately describe the services performed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.”
- 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.

- G0260 - Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography.
- Based on review of the operative report, provider states that one injection was performed on the right SI joint and a second injection on the left SI joint.
- 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.
- Based on information reviewed, reimbursement of code G0260 and G0260-51 is warranted. A 5% PPO discount is to be applied.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code G0260 and G0260-51 is recommended.**

Date of Service: 02/27/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
G0260	\$629.32	\$302.22	\$327.10	100%	\$597.85	<b>DISPUTED SERVICE:</b> Allow reimbursement \$295.63
G0260-50-51	\$314.66	\$151.11	\$163.55	50%	\$298.93	<b>DISPUTED SERVICE:</b> Allow reimbursement \$147.82

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