

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 29, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000609	Date of Injury:	11/12/1990
Claim Number:	[REDACTED]	Application Received:	04/21/2015
Assignment Date:	05/18/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/15/2014 – 10/15/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	G0260-SG and G0260-SB50		

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 \$195.00 for the review cost and \$1,031.25 in additional reimbursement for a total of \$1,226.25 A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$1,226.25** 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,

Paul Manchester, M.D., M.P.H.
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

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 seeking \$1,119.38 in remuneration for ASC G0260-SG & G0260-SG-50 (Bilateral) Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography, performed 10/15/2014.**
- Claims Administrator denied reimbursement based on unlisted code rational.
- 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.

- **§9789.16.5(f)** Multiple Procedures Including Bilateral Surgeries: If any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.
- UB-04, Bill type 831, reflects one line item billed as G0260 & G0260-50-51.
- Procedure documentation reflects fluoroscopic guidance indicating 20610 code reassignment does not fully represent the RVU's performed.
- G0260 code and 27096 Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or ct) including arthrography when performed, are typically utilized for billing SI Joint Injections performed with radiologic guidance. However, 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.
- A review of the Addendum AA, ASC Covered Surgical Procedures for CY 2014 does not list HCPCS code 27096, but it does list G0260. Addendum B for CY 2014 does not list an APC Relative weight for procedure code 27096 as this code is not reimbursable under OPPS. However, a relative weight is listed for HCPCS G0260. Therefore, the Provider correctly submitted HCPCS code G0260 for billing an OPPS anesthetic injection to sacroiliac joint with fluoroscopic guidance and reimbursement is warranted for the ASC payment rate for HCPCS G0260.
- Authorization for Date of Service 10/15/2014, signed by the Claims Administrator on 11/28/2014, indicates disputed HCPCS codes and the expected payment.
- **Pursuant to LC § 5307.11** – "the medical fee schedule shall not apply to the contracted reimbursement rates." California State Assembly Bill 1177 amended the Labor Code effective January 1, 2002 to add §5307.11:
 - LC § 5307.11 states: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.
- Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for G0260-SG and G0260-SG-50.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: G0260-SG and G0260-SG-50.

Date of Service: 10/15/2014						
Ambulatory Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
G0260-SG	\$1,900.00	\$0.00	\$746.25	1	\$825.00	PPO Contract
G0260-SG-50	\$950.00	\$0.00	\$373.13	1	\$206.25	PPO Contract

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