

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 19, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000652	Date of Injury:	04/01/1996
Claim Number:	[REDACTED]	Application Received:	04/20/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	01/18/2016		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	G0260-RT, 20552-59, and 20610-59RT		

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 \$965.03 in additional reimbursement for a total of \$1160.03. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$1160.03** 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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital 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 remuneration for G0260 - RT Status Indicator "T" injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography, 20552-59, Status Indicator "T" Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s) and 20610-59, Status Indicator "T" Arthrocentesis, aspiration and/or injection, major joint or bursa provided on 01/18/2016.**
- The Claims Administrator denied codes G0260 and 20552. Claims Administrator reimbursed 20610 \$216.26 with rationale "Priced according to state regs out-patient facility schedule"
- Provider billed disputed services on a UB04 with by type 0131 – Hospital Outpatient.
- Per OMFS Outpatient Hospital and Ambulatory Surgery Center Fee Schedule effective , status code indicators and APC Relative Weights are based on CMS Addendum AA and B effective for date of service on or after January 1, 2015.
- 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.

- HCPCS code G0260 has the assigned status indicator for this disputed code for 2014 is “T”. T = Significant Procedure, Multiple Reduction Applies. Paid under OPPS and separate APC payment. HCPCS code G0260 is grouped into APC 0207 Level III Nerve Injections.
- Section 9789.32. Applicability: For Other Services rendered on or after September 1, 2014 to hospital outpatients, the maximum allowable hospital outpatient facility fees shall be paid according to the OMFS RBRVS.
- OMFS § 9789.33 For services rendered on or after September 1, 2014 “S”, “T”, “X”, or “V”, “Q1”, “Q2”, or “Q3”. Status code indicators “Q1”, “Q2”, and “Q3” must qualify for separate payment. APC relative weight x adjusted conversion factor x 1.212 workers’ compensation multiplier, pursuant to Section 9789.30(aa).
- OMFS § 9789.30 (b) For services rendered on or after December 1, 2014, "APC Payment Rate" means CMS' hospital outpatient prospective payment system rate for Calendar Year **2014**.
- CPT 20552 and 20610 have Status indicator “T” and is subject to MPPR @ 50% of the Primary Procedure G0260.
- Contractual Agreement submitted states “Workers’ Compensation product shall be 93% of the maximum amount payable under applicable state or federal laws or regulations pertaining to the payment of occupational illness or injury bills”
- Provider reimbursed 20610 as the primary procedure which was incorrect. 20610 is subject to MPPR and overpayment will be applied to primary reimbursement owed.
- Opportunity for Claims Administrator to Dispute sent on 4/29/2016. A response was not received for this review.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for G0260 and 20550.**

The table on page 4 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: G0260-50, 20552-59 & 20610-59

Date of Service 01/18/2016						
HOPPS						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
G0260-50	\$1,623.00	\$0.00	\$907.41	1	\$907.40	PPO – Overpayment for 20610 = \$828.08 Due Provider
20552	\$811.50	\$0.00	\$136.95	1	\$136.95	\$136.95 Due to Provider
20610	\$811.50	\$216.26	-\$79.32	1	\$136.95	Overpayment of \$79.32

Copy to:

[REDACTED]
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