

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 13, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001505	Date of Injury:	09/30/1997
Claim Number:	[Redacted]	Application Received:	10/07/2014
Claims Administrator:	[Redacted]		
Assigned Date:	2/20/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	G0260 and 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 \$639.28 in additional reimbursement for a total of \$889.28. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$889.28 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, MD, MPH
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
- 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 code G0260 and G0260-50-51.
- Claims administrator reimbursed codes indicating on the Explanation of Review “Payment based on individual pre-negotiated agreement for this specific service.”
- Documentation received for this review included the Request for Authorization Approval by the Utilization Review department of the Claims Administrator. Specific Request: Bilateral SI joint block and follow up/ Approved by UR Nurse. Documentation states “This review applies only to the specific service(s) listed.” Listed are Pain Management for 1 unit and Office Visit for 1 Unit both to begin 11/27/2013 and end 1/17/2014. No pre-negotiated amount was listed on the Approved Authorization.
- Procedure Note submitted documents procedure performed that Provider billed for on a UB-04.
- Payment is based on the Outpatient Prospective Payment System. Multiple procedure reduction applies per status indicator ‘T’. Provider billed modifier -50 for bilateral joints injected. Allowance is increased 150% for bilateral procedures and reduced per multiple procedure reduction rule.
- Based on information reviewed, additional reimbursement is warranted for code G0260 and G0260-50.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code G0260 is recommended.

Date of Service: 12/19/2013						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
G0260-50	\$1900.00	\$304.70	\$639.28	2	\$943.98	DISPUTED SERVICE: Allow reimbursement \$639.28

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