MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 1, 2015

[redacted]

IBR Case Number:	CB15-0001533	Date of Injury:	09/04/2013
Claim Number:	[redacted]	Application Received:	09/03/2015
Assignment Date:	09/21/2015		
Claims Administrator:	[redacted]		
Date(s) of service:	05/11/2015 – 05/11/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	G0260-SG and G0260-SG-59		

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 $1,038.99 in additional reimbursement for a total of $1,233.99. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$1,233.99** 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]

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 $2,250.00 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 on 05/11/2015.**
- Claims Administrator denied reimbursement based on "bundling and unbundling," services.
- **CCR § 9789.30**, subsections (a) adjusted conversion factor, (e) APC payment rate, (f) APC relative weight, (j) Facility Only Services, (q) labor-related share, (r) market basket inflation factor, and (z) wage index, are adjusted to conform to the Medicare hospital outpatient prospective payment system (HOPPS) final rule of December 10, 2013, the relative values in the **2014** Medicare Physician fee schedule, and the wage index values in the Medicare IPPS final rule of August 19, 2013, and associated rules and notices to the IPPS final rule published in the Federal Register. The adjustments to these subsections are specified in section 9789.39 by date of service.
- **CCR § 9789.33** For services rendered on or after September 1, 2014, Status Indicators; "S, T, X, or V, Q1, Q2, or Q3" must qualify for separate payment." APC relative weight x adjusted conversion factor x 0.808 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.
- 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**," with a weight of "**9.2183**." 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-SG & G0260-SG-50.
- 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 <u>with radiologic guidance.</u> 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 <u>2014</u> 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 05/11/2015, signed by the Claims Administrator on 04/15/2015, indicates disputed HCPCs codes and the expected payment.
- 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: 05/11/2015 Ambulatory Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
G0260-SG	$1,500.00	$0.00	$1,500.00	1	$698.66	**OMFS**
G0260-SG-50	$750.00	$0.00	$750.00	1	$349.33	**OMFS**

Copy to:

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