MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 2, 2015

[redacted]

IBR Case Number:	CB15-0001828	Date of Injury:	10/02/2013
Claim Number:	[redacted]	Application Received:	10/06/2015
Claims Administrator:	[redacted]		
Date(s) of service:	06/24/2015 – 06/24/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	G0260		

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 $435.08 in additional reimbursement for a total of $630.08. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$630.08** 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
- 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 $435.48 remuneration for G0260 Status Indicator "T" injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography performed on 06/24/2015.**
- The Claims Administrator initially denied reimbursement based on "unlisted" code, then reimbursed $188.13 based on "comparable service." Comparable service code not indicated on EOR
- Provider billed disputed services as part of an ambulatory surgical center service on a UB04 with by type 831 – Ambulatory Surgery.
- 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.
- **CCR § 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.

- **CPT 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.
- **CCR § 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.**
- 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.
- **CCR § 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 0.808 workers' compensation multiplier, pursuant to Section 9789.30(aa).
- **CCR § 9789.16.5** Surgery – Multiple Surgeries and Endoscopies (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 indicates G0260.
- Procedure Documentation indicates Sacroiliac Joint Injection performed bilaterally substantiating submitted procedure G0260.
- Contractual Agreement not submitted for IBR.
- **Based on the aforementioned documentation and guidelines, reimbursment is warranted for G0260.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: G0260

Date of Service 06/24/2015							
Ambulatory Surgery							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
G0260	$2,850.00	$0.00	$1,119.38	N/A	1	**$623.21**	**$435.08 Due Provider Refer to Analysis**

Copy to:

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