

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)
- 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 - 50 Status Indicator “T” injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography and 20610 -50, Status Indicator “T” Arthrocentesis, aspiration and/or injection, major joint or bursa provided on 07/14/2015.**
- EOR’s reflect the Claims Administrator based denial of G0260 on “no allowance in fee schedule.” CPT 20610 Reimbursement rational based on “jurisdictional fee schedule adjustment.”
- Provider billed disputed services as part of an ambulatory surgical center service 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 January 1, 2014.
- **CCR § 5307.1(g)(2)**, the Acting Administrative Director of the Division of Workers’ Compensation orders that to the extent references to the Federal Register or Code of Federal Regulations are made in any sections starting from section 9789.30 through 9789.39 of Title 8 of the California Code of Regulations, said section is hereby amended to incorporate by reference the applicable Federal Register final rule (including additional notices, correction notices, and revisions) and Federal Regulations in effect as of the date this Order becomes effective, to be applied to services rendered on or after December 1, 2014. In particular, to the extent a section makes reference to the CMS hospital outpatient prospective payment system final rule, said section is amended to incorporate by reference the final rule published on December 10, 2013 in the Federal Register (Vol. 78 FR 74826)

and is entitled "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems. 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.

- **Codes G0260 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.
- 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 § 9789.32**. 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.
- **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 1.212 workers' compensation multiplier, pursuant to Section 9789.30(aa).
- **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**.
- CPT 20610 Status indicator "T" is subject to MPPR @ 50% of the Primary Procedure G0260.
- **CCR § 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.
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for G0260 – 50 & 20610 – 50.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: G0260 – 50 & 20610 – 50

Date of Service 07/14/2015							
HOPPS							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
G0260	\$2,434.50	\$0.00	\$1,463.55	N/A	1	\$1,463.55	(-) Overpayment for 20610 = \$1,242.45 Due Provider
20610	\$1,623.00	\$441.78	\$294.51	N/A	1	\$220.68	Refer to Analysis

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