

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 26, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0002211	Date of Injury:	09/04/2013
Claim Number:	[Redacted]	Application Received:	12/01/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	08/10/2015 – 08/10/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	G0260-SG and G0260-SG50		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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
- Medicare Billing Manual
- NCCI Edits
- AMA CPT
- OMFS

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 & G0260 - 50 Status Indicator “T” injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography performed on 08/10/2015.**
- The Claims Administrator denied reimbursement stating “Surgeon already billed for POS 11 which includes both professional and facility fees. No **additional** payment allowed,” and “The labor code does not sow coverage for office-based surgery center.”
- Authorization dated “July 31, 2015, indicates **bilateral** Sacroiliac Joint Injections as “certified.”
- Operative Report indicates the following: "A total of **2 sites** were injected."
- CMS 1500 indicates **3 (three) injections**.
- **CCR § 9789.16.6 Surgery – Bilateral Surgeries. (b)(1) Billing Instructions for Bilateral Surgeries** If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), report the procedure with modifier “-50.” (**NOTE:** This differs from the CPT coding guidelines which indicate that bilateral procedures should be billed as two line items.)
- **Article 5.5.0. Rules § 9792.5.7.** Requesting Independent Bill Review (b)(2) The proper selection of an analogous code or formula based on a fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11, unless the fee schedule or contract allows for such analogous coding.
- Incorrect formula for bilateral services submitted.
- G0260 Excluded from the Physician’s Fee Schedule.
- EOR denial notes indicate services reimbursed as POS “11,” and stated ‘No additional payment allowed.’ Services cannot be charged for under both ASC and Physician fee schedules. .
- Provider indicates facility is accredited to perform Ambulatory Surgery procedures. Accreditation Certificate not submitted for IBR and standing could not be verified with presented documentation.
- Submitted for review included a previously determined case. However, the Claims Administrator’s denial for said case referred to “bundling and unbundling” of services and not place of service, or a previous reimbursement under the Physician’s Fee Schedule.
- **Based on the documentation submitted, reimbursement for G0260 and G2060-50 is not supported.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: G0260, G0260-50

Date of Service: 08/10/2015 Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
G0260	\$1,500.00	\$0.00	\$1,500.00	1	\$0.00	Refer to Analysis
G0260	\$750.00	\$0.00	\$750.00	1	\$0.00	Refer to Analysis

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