

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 11, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0001857	<b>Date of Injury:</b>	03/07/2011
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	12/01/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	01/06/2015
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	82846 x 38 Units		

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 \$48.83 in additional reimbursement for a total of \$298.83. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$298.83 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]  
[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
- AMA CPT 2014

## 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 remuneration for 82486 x 38 units submitted for date of service 06/24/2015.**
- Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers' Compensation orders that the pathology and clinical laboratory fee schedule portion of the Official Medical Fee Schedule (OMFS) contained in title 8, California Code of Regulations, section 9789.50, has been adjusted to conform to the changes to the Medicare payment system that were adopted by the Centers for Medicare & Medicaid Services (CMS) for calendar year 2013. Effective for services rendered on or after January 1, 2013, the maximum reasonable fees for pathology and laboratory services shall not exceed 120% of the applicable California fees set forth in the calendar year 2012 Clinical Laboratory Fee Schedule. Based on the adoption of the CMS payment system, CMS coding guidelines and fee schedule were referenced during the review of this Independent Bill Review (IBR) case.
- Claims Administrator cited "medically unlikely edits" as reason for denial of 38 of 40 units.
- Provider submitted laboratory results for CPT 82486 documenting qualitative test results for the following drug categories: Narcotics/Analgesics, Opiates, Oxycodone, Methadone, Benzodiazepines, Barbiturates, Amphetamines, Tricyclic Antidepressants, Antidepressants, Neuropathic and Sedatives/Hypnotics and Validity Testing including; Creatinine, Nitrite, Glutaraldehyde, pH, S.G. & Oxidant/PCC.

- Authorization for “Urine Drug Screen” dated, 05/14/2015 does not indicate a specific CPT Code.
- The Provider conducted drug screening tests utilizing urine gas/chromatography method. Historically, urine drug screens electronically measured are reported with HCPCS code G0431; “any method.”
- HCPCS code G0431 is reported with only one unit of service regardless of the number of drugs screened. The testing described by G0431 includes all CLIA high complexity urine drug screen testing as well as any less complex urine drug screen testing performed at the same patient encounter.
- HCPCS G0431: Drug screen qualitative; multiple drug classes by high complexity test method (e.g. immunoassay, enzyme assay), per patient encounter.
- Reimbursement for G0431 is recommended.
- ERO Reflects 95% OMFS

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 82846 x 38 units.**

Date of Service 06/24/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
82846 as G0431	\$1,227.20	\$59.12	\$432.30	N/A	38	\$107.95	OMFS – Reimbursed Amount = \$48.83 Refer to Analysis

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