

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 10, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001879	Date of Injury:	02/25/1991
Claim Number:	[Redacted]	Application Received:	12/08/2014
Claims Administrator:	[Redacted]		
Assigned Date:	1/7/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, 82145-59, 82055, 82570		

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. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$250.00 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, MD, MPH
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
- Negotiated contracted rates: PPO Discount 15%
- National Correct Coding Initiatives

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 is seeking additional reimbursement for billed codes 82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, 82145-59, 82055, 82570
- Claims administrator made a partial payment indicating on the Explanation of Review “This charge was adjusted to comply with the rate and rules of the contract indicated.”
- 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.

- The CPT Codes in question will be defined utilizing the American Medical Association Current Procedural Code Book, 2014:
CPT 82145: AMPHETAMINE/METHAMPHETAMINE - QUANTITATIVE
CPT 82205: BARBITURATES NOT ELSEWHERE SPECIFIED- QUANTITATIVE
CPT 82520: COCAINE/METABOLITE
CPT 80154: QUANTITATIVE BENZODIAZEPINES
CPT 83840: METHADONE
CPT 83992: PHENCYCLIDINE
CPT 83925: OPIATE(S) DRUG AND METABOLITES EACH PROCEDURE :
Opiate(s), drug and metabolites, each procedure
CPT 82055: ALCOHOL ANY SPECIMEN EXCEPT BREATH
CPT 82570: CREATININE OTHER SOURCE
MODIFIER -59: Distinct Procedural Service
- The Provider states the “medical office holds a Clinical Laboratory License as a high complexity laboratory (effective 06/28/10).” The analyzer utilized to perform the assays is an “Olympus AU400 and AU640.” According to the manufacturer, this dual analyzer is classified as a “high complexity” unit.
- Moderate v. High complexity as defined by Centers for Disease Control Clinical Laboratory Improvement Amendments (CLIA), “Clinical laboratory test systems are assigned a moderate or high complexity category on the basis of seven criteria given in the CLIA regulations. For commercially available FDA-cleared or approved tests, the test complexity is determined by the FDA during the pre-market approval process. For tests developed by the laboratory or that have been modified from the approved manufacturer’s instructions, the complexity category defaults to high complexity per the CLIA regulations, See 42 CFR 493.17.
- A similar code historically assigned for CPT Codes 82145, 83925, 83925-59, 83992, 83840, 82520, 80154, 82205 & 82145-59 is G0431, “multiple drug classes by high complexity test method.” Given the documentation provided and the aforementioned guidelines discussed, it is recommended that the Disputed Codes: 82145, 83925, 83925-59, 83992, 83840, 82520, 80154, 82205 & 82145-59 be reimbursed as code G0431 in accordance with Title 8, California Code of Regulations, §9789.50 Laboratory Fee Schedule.
- The last two Disputed Codes 82055 and 82570 are not inclusive to G0431 and it is recommended that these two codes be reimbursed separately in accordance with Title 8, California Code of Regulations, §9789.50 Laboratory Fee Schedule.
- Based on information reviewed, additional reimbursement of HCPCS code G0431 and CPT codes 82055 and 82570 is warranted.
- Claims administrator submitted additional payment for all codes submitted after this dispute was filed. Claims administrator is responsible to reimburse provider the IBR application fee of \$250.00

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of codes G0431, 82055 and 82570 is recommended.

Date of Service: 6/4/2014							
Laboratory Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
G0431	\$533.00	\$203.33	N/A	1	N/A	\$101.18	DISPUTED SERVICE: No further reimbursement recommended
82055	\$33.00	\$15.04	N/A	1	N/A	\$15.04	DISPUTED SERVICE: No further reimbursement recommended
82570	\$18.00	\$7.20	N/A	1	N/A	\$7.20	DISPUTED SERVICE: No further reimbursement recommended

Copy to:

██████████
 ████████████████████
 ████████████████████████████████

Copy to:

██
 ██
 ██