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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 8, 2015

[redacted]

IBR Case Number:	CB15-0001348	Date of Injury:	03/14/2012
Claim Number:	[redacted]	Application Received:	08/14/2015
Claims Administrator:	[redacted]		
Date(s) of service:	02/25/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	G6040		

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 $17.64 in additional reimbursement for a total of $212.64. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $212.64 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]

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

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 dissatisfied with denial of HCPCS G6040
- 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.
- Provider originally billed code 80320, DRUG SCREEN QUANTITATIVE ALCOHOLS.
- Provider resubmitted a corrected claim dated 6/30/2015 with new HCPCS code G6040 which Claims Administrator did deny with code 99199 per EOR dated 7/10/15.
- Provider submitted test results for Ethanol for date of service 2/25/2015
- Based on information reviewed, reimbursement of G6040 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code G6040

Date of Service: 02/25/2015						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
G6040	$30.00	$0.00	$30.00	1	$17.64	**DISPUTED SERVICE**: Allow reimbursement $17.64

Copy to:

[redacted]

Copy to:

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