

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

September 22, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001413	Date of Injury:	10/17/2012
Claim Number:	[REDACTED]	Application Received:	08/21/2015
Assignment Date:	09/10/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	01/29/2015 – 01/29/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99215 & G0431		

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 \$124.37 in additional reimbursement for a total of \$319.37. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$319.37** 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
- PPO Contract: 90% 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 seeking remuneration for 99215 Evaluation and Management service and G0431 Urine Drug Screen, performed on 01/29/2015.**
- The Claims Administrator down-coded **99215 to 99214 & G0431 to G0431** with the following rational: “better defining service.”
- The determination of an Evaluation and Management service for Established Patients require **two of three key components** in the following areas (AMA CPT 1995/1997):
  - 1) **History:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
  - 2) **Examination:** “The 1995 documentation guidelines state that the medical record for a general multi-system examination should include findings about eight or more organ systems.”
  - 3) **Medical Decision Making Medical** decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:
    - a. The number of possible diagnoses and/or the number of management options that must be considered;
    - b. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
    - c. The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

- To determine the level of service in a given **component** of an E&M, the data must “meet or exceed” the elements required.
- 1995/1997 Evaluation and Management Levels/Elements (History / Exam / Medical Decision Making), Established Patient:
  - 99212: Problem Focused / Problem Focused / Straight Forward
  - 99213: Expanded Problem Focused / Expanded Problem Focused / Low Complexity
  - 99214: Detailed History / Detailed Exam / Moderate Complexity
  - 99215: Comprehensive / Comprehensive / High
- **Time:** In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services. The total length of time of the encounter (faced-to-face) should be documented and the record should **describe the counseling and/or activities to coordinate care.**
- Abstracted information for date of service 01/29/2015 revealed the following level of service:
  - History: **Comprehensive**
    - HPI Extensive >4 elements
    - Complete ROS
    - > 2 areas Other History
  - Exam: **Expanded Problem Focused**
  - Medical Decision Making: **Comprehensive**
    - Multiple Management Options/Diagnoses
    - Extensive Complexity of Data (“15 min. record review”)
    - Risk = high, Opioid Therapy and other Pain Management Medications Documented.
  - Comprehensive / Expanded Problem Focused / Comprehensive = 2 of 3 meet or exceed = 99215

**Time Factor for date of service:**

○ N/A

- 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 2014. 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.
- 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.

- As defined by the US Centers for Medicare and Medicaid Services **HCPCS G0434**: (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) will be used to report very simple testing methods, such as dipsticks, cups, cassettes, and cards, that are interpreted visually, with the assistance of a scanner, or are read utilizing a moderately complex reader device outside the instrumented laboratory setting (i.e., non-instrumented devices). This code is also used to report any other type of drug screen testing using test(s) that are classified as Clinical Laboratory Improvement Amendments (CLIA) moderate complexity test(s), keeping the following points in mind: includes qualitative drug screen tests that are waived under CLIA as well as dipsticks, cups, cards, cassettes, etc, that are not CLIA waived.
- As defined by the US Centers for Medicare and Medicaid Services (CMS), **HCPCS G0431** is defined as follows: G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) will be used to report more complex testing methods, such as multi-channel chemistry analyzers, where a more complex instrumented device is required to perform some or all of the screening tests for the patient. This code may only be reported if the drug screen test(s) is classified as CLIA high complexity test(s) with the following restrictions:
  - May only be reported when tests are performed using instrumented systems (i.e., durable systems capable of withstanding repeated use).
  - CLIA waived tests and comparable non-waived tests may not be reported under test code G0431; they must be reported under test code G0434.
  - CLIA moderate complexity tests should be reported under test code G0434 with one (1) Unit of Service (UOS).
  - G0431 may only be reported once per patient encounter.
- Lab Report for date of service reflects high complexity (“instrumented”) computerized quantitative analysis. As such, the re-assigned **G0434 Code is incorrect.**
- Provider states “Center holds a CLIA Certificate of Accreditation, #, (not a CLIA certificate waiver).” A copy of the Provider’s current Laboratory license was submitted for review.
- **Based on the aforementioned documentation and guidelines, reimbursement for Evaluation and Management Level 99215 & G0431 is supported.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99215 & G0431**

<b>Date of Service: 01/29/2015</b>							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99215	\$210.00	\$112.63	\$97.37	N/A	1	\$150.44	Reimbursed Amount – PPO = \$37.81 Due Provider
G0431	\$1,260.00	\$21.38	\$1,238.62	NA	1	\$107.95	Reimbursed Amount – PPO = \$86.56 Due Provider

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