

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 7, 2016

[Redacted]

IBR Case Number:	CB16-0000428	Date of Injury:	04/29/1990
Claim Number:	[Redacted]	Application Received:	03/15/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	12/08/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	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 \$109.25 in additional reimbursement for a total of \$304.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$304.25** 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

[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

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 \$109.25 in remuneration for G0431 Urine Drug Screen for date of service 12/08/2015.**
- EOR indicates services denied per “procedure not in provider scope of practice.”
- Opportunity to Dispute Eligibility communicated with Claims Administrator on 03/16/2016; response not yet received.
- **CCR § 9789.50 (a)** Pathology and Laboratory: Effective for services after January 1, 2004, the maximum reasonable fees for pathology and laboratory services shall not exceed one hundred twenty (120) percent of the rate for the same procedure code in the CMS' Clinical Diagnostic Laboratory Fee Schedule, as established by Sections 1833 and 1834 of the Social Security Act (42 U.S.C. §§ 1395l and 1395m) and applicable to California
- 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 (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

