

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 11, 2016

[Redacted]

IBR Case Number:	CB16-0000476	Date of Injury:	04/27/1999
Claim Number:	[Redacted]	Application Received:	03/21/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	09/15/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	G6041, G6045, G6046, G6056, and G6031		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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 remuneration for G6041, G6045, G6046, G6056, and G6031 for date of service 09/15/2015. Provider billed codes along with G0431.**
- The Claims Administrator denied codes G6041, G6045, G6046, G6056, and G6031 indicating “service is included within the value of another service performed on the same day,” and reimbursed G0431 indicating “This charge was adjusted to comply with the rate and rules of the contract indicated.”
- **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 **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.
- Additional lab services do not appear to be authorized as Provider marked ‘No’ on application
- Authorization was not submitted for review.
- **Based on the aforementioned documentation and guidelines, reimbursement is not indicated for G6041, G6045, G6046, G6056, and G6031.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: G6041, G6045, G6046, G6056, and G6031

Date of Service: 09/15/2015							
Laboratory Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
G6041, G6045, G6046, G6056, and G6031	\$222.88	\$106.88	\$186.69	N/A	1	\$106.88	Refer to Analysis

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

[REDACTED]
 [REDACTED]
 [REDACTED]
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