

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 25, 2016

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB16-0000531	Date of Injury:	06/11/2015
Claim Number:	[Redacted]	Application Received:	04/01/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	12/02/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	84481, 84439, 84443, 80048, 80076, 84550, 82977, 82728, 82306, 82172 x 2, and 83036		

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 \$224.84 in additional reimbursement for a total of \$419.84. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$419.84 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: N/A
- 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 seeking remuneration for billed codes 84481, 84439, 84443, 80048, 80076, 84550, 82977, 82728, 82306, 82172 x 2, and 83036 on date of service 12/02/2015
- Provider was requested as a QME.
- Claims Administrator bundled codes into HCPCS G0434 and reimbursed \$23.75 with indication “Changed to G0434 better defining services performed.” Claims Administrator’s reimbursement of \$23.75 is acceptance of “authorized” services performed.
- G0434: Drug screen, other than chromatographic; any number of drug classes, by clia waived test or moderate complexity test, per patient encounter.
- Documentation submitted for review included Provider’s Panel Qualified Medical Evaluation in Internal Medicine and Toxicology report, lab results, ECG report and Pulmonary Function Analysis.
- Lab tests performed were chemistry procedures to determine issues with the injured worker’s exposure to mold over the last 10 to 20 years.
- Laboratory tests are not included in G0434 drug screening panel.
- §9789.50 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. The Clinical Diagnostic Laboratory Fee Schedule, which can be found on the CMS Internet Website

- Based on aforementioned documentation, additional reimbursement for disputed codes is indicated.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 84481, 84439, 84443, 80048, 80076, 84550, 82977, 82728, 82306, 82172 x 2, and 83036 on date of service 12/02/2015

Date of Service: 12/02/2015					
Laboratory Services					
Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
\$248.59	\$23.75	\$224.84	1	\$248.59	\$224.84 Due to Provider

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
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