

**MAXIMUS FEDERAL SERVICES, INC.**

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

May 2, 2016

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

IBR Case Number:	CB16-0000538	Date of Injury:	11/01/2012
Claim Number:	[REDACTED]	Application Received:	04/04/2016
Assignment Date:	04/21/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/06/2015 – 07/06/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	G6041, G6045, G6046		

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 \$118.47 in additional reimbursement for a total of \$313.47. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$313.47** 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,

[REDACTED], 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
- 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 G6041, G6045, and G6046 performed on 07/06/2015.**
- Opportunity to Dispute Eligibility communicated with the Claims Administrator on 04/05/2016, response revived 04/16/2016. The Claims Administrator indicates service denied due to “no quantitative results.”
  - Laboratory Results submitted by the Claims Administrator indicates qualitative analysis.
- HCPCS G6041, G6045, G6046: Assay of urine alkaloids, Assay of dihydrocodeinone and dihydromorphinone
- Submitted lab reports by the Provider includes a qualitative analysis (positive/negative) and a quantitative analysis for: barbituates results, negative @ <0 (G6041); Opiates results, negative @ < 0 (G6045); and Oxycodone results positive at “666.6 ng/ml” (G6046).
- 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.
- Contractual Agreement indicates 95% OMFS.
- **Based on the aforementioned documentation and guidelines, reimbursement for G6041, G6045 and G6046 is indicated.**

The table on page 4 describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: G6041, G6045 and G6046**

<b>Date of Service:</b> 07/06/2015 Laboratory Services						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
G6041 G6045 G6046	\$185.12	\$0.00	\$124.71	1	\$118.47	<b>PPO</b> Refer to Analysis

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]