

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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Fax: (916) 605-4280

**Independent Bill Review Final Determination Reversed**

9/23/2014

████████████████████  
██████████  
████████████████████

IBR Case Number:	CB13-0000722	Date of Injury:	10/11/2012
Claim Number:	██████████	Application Received:	11/12/2013
Claims Administrator:	████████████████████		
Date(s) of service:	05/16/2013 -05/16/2013		
Provider Name:	████████████████████		
Employee Name:	██████████		
Disputed Codes:	82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, 82145-59, 82055, & 82570		

Dear ██████████:

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/28/2014, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$117.93, for a total of \$452.93.**

**Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed - The following evidence was used to support the decision:**

- 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 or negotiated contract: PPO Contract

- Other: CMC Coding & Payment System

### Supporting Analysis:

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 2013. 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.

The dispute regards the denial of services for CPT Codes, 82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, 82145-59, 82055, & 82570 for date of service 05/16/2013. The Provider billed \$584.00 and was reimbursed \$23.99 by the Claims Administrator. The Provider is seeking additional reimbursement of \$242.15.

The Claims Administrator based reimbursement of the CPT codes in question on HCPCS G0434 with the explanation: "G0434 Better Defining Services Performed."

As defined by the US Centers for Medicare and Medicaid Services (CMS), G0434 is defined as follows:

- 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.

The CPT Codes in question will be defined utilizing the American Medical Association Current Procedural Code Book, 1997:

- **CPT 82145: AMPHETAMINE/METHAMPHETAMINE - QUANTITATIVE**

- **CPT 82205:** BARBITURATES NOT ELSEWHERE SPECIFIED- **QUANTITATIVE**
- **CPT 80154:** QUANTITATIVE BENZODIAZEPINES
- **CPT 82520:** COCAINE/METABOLITE
- **CPT 83840:** METHADONE
- **CPT 83992:** PHENCYCLIDINE
- **CPT 83925:** OPIATE(S) DRUG AND METABOLITES EACH PROCEDURE : Opiate(s), drug and metabolites, each procedure
- **CPT 82055:** ALCOHOL ANY SPECIMEN EXCEPT BREATH
- **CPT 82570:** CREATININE OTHER SOURCE
- **MODIFIER -59:** Distinct Procedural Service

The Provider states the “medical office holds a Clinical Laboratory License as a high complexity laboratory (effective 06/28/10).” The analyzer utilized to perform the assays is an “Olympus AU400 and AU640.” According to the manufacturer, this dual analyzer is classified as a “high complexity” unit.

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.

Due to the high complexity of the toxicology test performed; results report a computerized quantitative measure of each drug screened, and the fact that the computer system utilized to determine the results is not CLIA waved and the Provider’s laboratory is licensed, the code assignment G0434 is incorrect.

A similar code historically assigned for CPT Codes 82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, & 82145-59 is G0431, “multiple drug classes by high complexity test method.” Given the documentation provided and the aforementioned guidelines discussed, it is recommended that the Disputed Codes: 82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, & 82145-59, be reimbursed as code G0431 in accordance with Title 8, California Code of Regulations, §9789.50 Laboratory Fee Schedule.

The last two Disputed Codes 82055 and 82570 are not inclusive to G0431 and it is recommended that these two codes be reimbursed separately in accordance with Title 8, California Code of Regulations, §9789.50 Laboratory Fee Schedule.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Units	Dispute Amount	OMFS Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
82145	1	\$22.01	\$0.00	\$ 2.18	\$0.00	OMFS
82205	1	\$22.01	\$0.00	\$ 2.18	\$0.00	OMFS
80154	1	\$22.01	\$0.00	\$ 2.18	\$0.00	OMFS
82520	1	\$22.01	\$0.00	\$ 2.18	\$0.00	OMFS
83840	1	\$22.01	\$0.00	\$ 2.18	\$0.00	OMFS
83992	1	\$22.01	\$0.00	\$ 2.18	\$0.00	OMFS
83925	1	\$22.01	\$0.00	\$ 2.18	\$0.00	OMFS
83925-59	1	\$22.01	\$0.00	\$ 2.18	\$0.00	OMFS
82145-59	1	\$22.01	\$0.00	\$ 2.18	\$0.00	OMFS
82055	1	\$22.01	\$17.82	\$ 2.18	\$15.64	OMFS
82570	1	\$22.01	\$8.53	\$ 2.19	\$6.34	OMFS
G0431	1	\$0.00	\$119.94	\$0.00	\$119.94	OMFS
		<b>\$242.15</b>		<b>\$23.99</b>	<b>\$141.92</b>	
		<b>TOTAL</b>	<b>\$141.92</b>	<b>- \$23.99</b>	<b>\$117.93</b>	<b>OMFS</b>

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT codes: 82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, 82145-59, 82055, & 82570 (**\$117.93**) for a total of **\$452.93**.

***The Claims Administrator is required to reimburse the provider \$452.93 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).***

Sincerely,

██████████, RHIT  
Chief Coding Reviewer

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