

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

9/12/2014

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

IBR Case Number:	CB14-0000116	Date of Injury:	10/05/1976
Claim Number:	[REDACTED]	Application Received:	01/27/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	09/25/2013 – 09/25/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	G0431		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/21/2014, 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 \$97.15, for a total of \$432.15.**

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, CDC - CLIA

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 amount for G0431 for date of service 09/25/13. The Provider billed HCPCS G0431 and was reimbursed \$22.79 by the Claims Administrator. The Provider is seeking additional reimbursement of \$97.15.

The Claims Administrator based its reimbursement of HCPCS G0431 on "G0434" with the explanation, "Documentation does not support the level of service." To better understand the definition of these two codes in question a definition, as defined by the US Centers for Medicare and Medicaid Services (CMS), will be provided below.

- HCPCS G0431: Drug screen, qualitative; multiple drug classes by high complexity test method (e. g., immunoassay, enzyme assay), per patient encounter
- HCPCS G0434: Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter

While reviewing the materials provided, it is noted that the results of the urine drug screen clearly indicate a computerized analysis was performed. Additionally, the Provider's Clinic is licensed in the state of California to perform High Complexity Labs.

Moderate Vs. 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."

Upon review of Centers for Medicare & Medicaid Services (CMS) guidelines, HCPCS code G0434 is utilized to report urine drug screening performed by a test that is CLIA waived or moderate complexity test.

The testing described by G0431 includes all CLIA high complexity urine drug screen testing as well as any less complex urine drug screen testing performed at the same patient encounter.

Due to the high complexity of the toxicology test performed; results report a computerized quantitative measure of each drug screened. The fact that the computer system utilized to determine the results is not CLIA waved and the Provider's Laboratory is licensed, the billed services shall be paid in accordance with HCPCS code G0431.

The drug screen services provided were of high complexity test method. The HCPCS code G0431 criteria has been met based on the documentation submitted by the Provider. Therefore, the code assignment G0434 and payment made by the Claims Administrator was not appropriate. The additional reimbursement of \$97.15 is warranted per the Official Medical Fee Schedule code G0431.

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	PPO Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
G0431	1	\$97.15	\$119.94	\$22.79	\$97.15	PPO Contract

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 code G0431 (\$97.15) for a total of \$432.15.

The Claims Administrator is required to reimburse the provider \$432.15 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

Copy to:

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