

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

9/19/2014

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

IBR Case Number:	CB14-0000045	Date of Injury:	03/27/2004
Claim Number:	[REDACTED]	Application Received:	01/13/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	05/28/2013 – 05/28/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	82145,82205,80154,82520,83480,83992,83925,83925-59,82145-59,82055, & 82570		

Dear [REDACTED]

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 \$0.00, for a total of \$335.00.**

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
- AMA CPT 1997, CMC Coding & Payment System

Supporting Analysis:

The dispute regards the denial of service CPT codes; 82145, 82205, 80154, 82520, 83480, 83992, 83925, 83925-59, 82145-59, 82055, & 82570, for date of service 05/28/2013. The services were denied by the Claims Administrator for the following reason:

“Quantitative testing of a negative qualitative result does not provide further information to substantiate the billed charges.”

The services in question are represented by quantitative testing CPT codes defined as follows by the 1997 American Medical Association Current Procedural Terminology Code Book:

- 82145: Amphetamine/methamphetamine
- 82205: Barbiturates not elsewhere specified
- 80154: Benzodiazepines
- 82520: Cocaine or metabolite
- 83840: Methadone
- 83922: Phencyclidine (PCP)
- 83925: Opiates (e.g., morphine, meperidine)
- 82570: Creatinine other sources

The Claims Administrator reviewed the claim a third time and bundled the above codes into one code and has reimbursed the provider for the services in question based on the new code. Below is a timeline for clarification:

- 06/26/13 - Claim Denied by Claims Administrator
- 12/06/13 - Claim Reconsidered and Denied by Claims Administrator
- 01/13/14 - Provider Requests IBR by Maximus
- 03/12/14 - Provider Request Deemed Eligible for IBR
- 03/19/14 - Claims Administrator Bundled Codes, \$146.29
- 04/16/14 – Letter from Provider Indicating IBR to proceed

As the timeline indicates, the Provider wishes to continue with the review and is seeking remuneration of the IBR fee from the Claims Administrator, and acknowledgement of the paid claim.

It must be understood that this review is being conducted with limited patient history; the relative EOR's, CMS1500 and lab findings represented by the CPT Codes in question are all that is available. There isn't a contractual agreement specifying what the reimbursement or agreement is for the codes in question. Because the information is limited, this decision is based on the narrative history provided in the information available for dates 06/23/13 – 03/12/2014.

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 following are facts relative to the case:

- The Provider is a Pain Management Specialist
- The Patient is being treated for:
 1. 729.1 — Myalgia and myositis nos Myalgia and myositis, unspecified
 2. 304.90 — Drug depend nos-unspec Unspecified drug dependence, unspecified
 3. V58.83 — Therapeutic drug monitor, Encounter for therapeutic drug monitoring
 4. V58.69 — Long-term use meds nec, Long-term (current) use of other medications
- Quantitative Urine Drug Screen Performed to verify compliance relative to Diagnosis 2 – 4.
- Authorization for Quantitate Urine Drug Screen not present in documentation.

Per the CMS Guidelines the codes in question are bundled into one HCPCS code. The code relative to the testing performed is:

- **HCPCS G0431:** Drug screen, qualitative; multiple drug classes by high complexity test method (e. g., immunoassay, enzyme assay), per patient encounter.

Since the patient is being monitored by the Physician on the basis of diagnoses 2 – 4, the quantitative Urine Drug Screen is warranted and reimbursement is recommended based on HCPCWS G0431.

The additional reimbursement of \$0.00 for Official Medical Fee Schedule code G4031 is warranted.

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	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
G0431	1	\$239.79	\$119.94	\$119.94	\$0.00	OMFS
82055	1	\$17.82	\$17.82	\$17.82	\$0.00	OMFS
82570	1	\$8.53	\$8.53	\$8.53	\$0.00	OMFS

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 (**\$0.00**) for a total of **\$335.00**.

The Claims Administrator is required to reimburse the provider \$335.00 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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