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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 23, 2014

[redacted]

IBR Case Number:	CB14-0000303	**Date of Injury:**	1/11/2011
Claim Number:	[redacted]	**Application Received:**	3/3/2014
Claims Administrator:	[redacted]		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	82145, 82205, 80154, 80299-59 (x2), 82520, 83840, 83925-59 (x2), 83986, 83992, 81002 & 80152		

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. IBR Case Assigned: 4/17/2014

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 $335.00 for the review cost and $95.47 in additional reimbursement for a total of $430.47.A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $430.47 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 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

[redacted]
Chief Coding Reviewer

cc: [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: 90% per PPO
- 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 is dissatisfied with reimbursement of billed codes 82145, 82205, 80154, 80299-59 (x2), 82520, 83840, 83925-59 (x2), 83986, 83992, 81002 & 80152.
- Provider was reimbursed $21.59 and is seeking additional reimbursement of $324.63.
- Claims Administrator bundled the billed 82145, 82205, 80154, 80299-59 (x2), 82520, 83840, 83925-59 (x2), 83986, 83992, 81002 & 80152 into HCPCS G0434 indicating the following on the Explanation of Review (EOR): "Based on the documentation submitted, the service performed is a Routine Drug Screen. Per CMS the Drug Screen CPT's were changed to G0431 for labs and G0434 for Physicians. The service is a PER patient encounter CPT. Refer to CMS.GOV." and for the subsequent CPT codes - "No separate payment was made because the value of the service is included within the value of another service performed on the same day".
- The Provider submitted a copy of the laboratory test results and Provider's Clinical Laboratory license. The toxicology results submitted report a quantitative measure of each drug screened (Amphetamine, Barbiturates, Benzodiazepine, Cannabinoids, Cocaine Metabolites, Ecstasy, Methadone Metabolite, Opiates, Oxycodone, PCP, and Tricyclic's). HCPCS code G0434 is utilized to report urine drug screening performed by a test that is CLIA waived or moderate complexity test. Due to the complexity of the toxicology test performed, the levels tracked and results obtained the billed procedure codes 82145,

82205, 80154, 80299-59 (x2), 82520, 83840, 83925-59 (x2), 83992 & 80152 shall be paid in accordance with HCPCS code G0431. The HCPCS code G0431 is reported with only one unit of service regardless of the number of drugs screened. The testing described by G0431 includes all CLIA high complexity urine drug screen testing performed at the same patient encounter.

- The description of HCPCS code G0431 is "Drug screen, qualitative; multiple drug classes by high complexity test method (e.g. immunoassay, enzyme assay), per patient encounter."
- 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 correct.
- The billed procedure code CPT 83986 and 81002 are not considered part of the drug panel and should be paid separately. The description of CPT 83986 is "pH; body fluid, not otherwise specified." The description of CPT 81002 is "Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy".
- PPO Contract was received and a 10% discount is to be applied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the documentation submitted, additional reimbursement of $95.47 to be made based on the Official Medical Fee Schedule for HCPCS code G0431 and CPT codes 81002 & 83986.

Date of Service: 8/21/2013							
[redacted]							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Asst. Surgeon**	**Workers' Comp Allowed Amt.**	**Notes**
G0431	$ 452.00	$ 21.59	$ 269.60	1	N/A	$ 107.95	**DISPUTED SERVICE**: Additional Reimbursement Allowed in the amount of $86.36 per PPO Contract.
83986	$ 53.00	$ 0.00	$ 31.92	1	N/A	$5.31	**DISPUTED SERVICE:** Additional Reimbursement Allowed in the amount of $5.31 per PPO Contract.
81002	$ 7.00	$ 0.00	$ 4.22	1	N/A	$3.80	**DISPUTED SERVICE:** Additional Reimbursement Allowed in the amount of $3.80 per PPO Contract.

Copy to:

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