

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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Fax: (916) 605-4280



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 15, 2014

[Redacted]

\*Consolidated Review for Two Injured Workers on two separate dates of service

<b>IBR Case Number:</b>	CB14-0000628	<b>Date of Injury:</b>	09/26/2012 (IW1) 03/03/2003 (IW2)
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	04/21/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	08/22/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	82486		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.**

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]

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:
- National Correct Coding Initiatives
- Other: CMS' National Correct Coding Initiative Guidelines 1/1/2013

## 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 code 82486 on two injured workers for two separate dates of service.
- Claims Administrator bundled the billed procedure code 82486 x multiple units into HCPCS G0431 for both injured workers and indicated on both the Explanations of Review "Based on the documentation submitted, the service performed is a Routine Drug Screen. Per CMS the Drug Screen CPTs were changed to G0431 for labs and G0434 for physicians. The service is a PER patient encounter CPT. Refer to CMS.GOV for more info."
- Provider submitted laboratory results (on both dates of service) for the CPT code 82486 documenting qualitative test results for the following drug categories: Narcotics/Analgesics, Opiates, Oxycodone, Methadone, Benzodiazepines, Barbiturates, Amphetamines, Tricyclic Antidepressants, Antidepressants, Neuropathic and Sedatives/Hypnotics. Although the results of the laboratory reports may have been different, the drug categories described were the same on both reports for both dates of service.
- Provider billed laboratory services on a CMS-1500 form with CPT 82486 x multiple units for both dates of service. No documents have been submitted to support the necessity for CPT 82486 x 4multiple units. Only CMS-1500 form and 2 page lab results of the aforementioned chemicals can be taken into consideration during this review for

both dates of service. In addition, the ICD-9 code is not coded to the highest specificity for CPT 82486 x multiple units on both dates of service.

- The Provider conducted drug screening tests (on both dates of service) utilizing the Chromatography method. The HCPCS code G0431 can be used for any method. 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 as well as any less complex urine drug screen testing performed at the same patient encounter.
- HCPCS G0431: Drug screen qualitative; multiple drug classes by high complexity test method (e.g. immunoassay, enzyme assay), per patient encounter.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on information received, additional reimbursement of HCPCS code G0431, the Claims Administrator was correct. There is no additional reimbursement warranted for the Official Medical Fee Schedule codes 82486(G0431)**

Date of Service: 1/8/2014 (IW1) and 5/16/2013 (IW2)						
Pathology and Clinical Laboratory						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
G0431 (IW1)	\$552.24	\$119.04	\$417.07	Multiple	\$119.04	<b>DISPUTED SERVICE:</b> No additional reimbursement recommended.
G0431 (IW2)	\$1227.20	\$119.94	\$1071.42	Multiple	\$119.94	<b>DISPUTED SERVICE:</b> No additional reimbursement recommended.

Copy to:

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