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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 02, 2015

[redacted]

IBR Case Number:	CB14-0001490	**Date of Injury:**	01/03/2013
Claim Number:	[redacted]	**Application Received:**	10/07/2014
Claims Administrator:	[redacted]	**Assignment Date:**	11/07/2014
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, 82145-59, 82055 and 82570		

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: 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 $250.00 for the review cost and $105.83 in additional reimbursement for a total of $355.83. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $355.83 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 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]
Medical Director

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

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 codes 82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, 82145-59, 82055 and 82570.
- Claims Administrator reimbursed three codes in the amount of $30.90 indicating on the Explanation of Review "Reimbursement is based on the applicable reimbursement fee schedule. The charge exceeds the Official Medical Fee Schedule allowance."
- The Provider submitted a copy of the laboratory test results. The toxicology results submitted report a quantitative measure of each drug screened (Amphetamine, Barbiturates, Benzodiazepine, Cocaine Metabolites, Ecstasy, Methadone, Opiates, Oxycodone, Phencyclidine, Creatinine and Ethyl Alcohol). Due to the complexity of the toxicology test performed, the levels tracked and results obtained the billed procedure codes 82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, 82145-59 & 82570 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 as well as any less complex 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.
- The billed procedure code CPT 82055 is not considered part of the drug panel and should be paid separately. The description of CPT 82055 is " Alcohol any specimen except breath."
- Based on information reviewed, additional reimbursement is warranted for G0431 and 82055.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code G0431 and 82055 is recommended.

Date of Service: 3/18/2014							
Pathology and Clinical Laboratory							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
G0431	$551.00	$30.90	$518.00	1	N/A	$119.04	**DISPUTED SERVICE**: Allow reimbursement $88.14
82055	$33.00	$0.00	$33.00	1	N/A	$17.69	**DISPUTED SERVICE**: Allow reimbursement $17.69

Copy to:

[redacted]

Copy to:

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