

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 11, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

Injured Worker 1 (IW1): [REDACTED]  
Injured Worker 2 (IW2): [REDACTED]

IBR Case Number:	CB14-0001686	Date of Injury:	02/16/1988 (IW1); 01/13/2012 (IW2)
Claim Number:	[REDACTED]	Application Received	11/10/2014
Employee Name	Refer to IW1 & IW2 above	Application Assigned	01/06/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	06/27/2014 (IW1); 06/16/2014 (IW2);		
Provider Name:	[REDACTED]		
Disputed Codes	82846 x 80 Units		

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,  
Paul Manchester, M.D., M.P.H.  
Medical Director

cc: [REDACTED]  
[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

## 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 seeking remuneration for 82486 Urine Drug Screen x 80 Units, provided to two Injured Workers (@40 units each) for dates of service 06/27/2014 and 06/06/2014.**
- 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.
- IW1, Claims Administrator denied 40 units of 89842 with the following 2 explanations: 1) "This service requires prior authorization and none was identified." 2) "Pre-authorization not obtained."
- IW2, Claims Administrator denied 40 units of 89842 with the following explanations: "Unnecessary Medical Treatment or Service."

- Provider submitted laboratory results for CPT 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 and Validity Testing including; Creatinine, Nitrite, Glutaraldehyde, pH, S.G. & Oxidant/PCC.
- IW1: The Provider billed laboratory services on a CMS-1500 form with CPT 82486 x 40 units along with **ICD-9 722.10, Lumbar Disc Displacement & 724.4 Lumbosacral Neuritis, NOS.**
- IW2: The Provider billed laboratory services on a CMS-1500 form with CPT 82486 x 40 units along with **ICD-9 722.10, Lumbar Disc Displacement & 724.4 Lumbosacral Neuritis, NOS & 722.6 Disc degeneration, NOS**
- Authorization specific to CPT 82846 could not be identified in the documentation provided for IBR.
- The diagnosis codes for each Injured Worker do not support the need for urine drug testing. For example, a Primary Diagnosis Code of V58.69, Encounter for therapeutic drug monitoring, would help support the need for urine drug testing.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 82846 x 80 units.**

Date of Service 06/27/2014 (IW1), 06/16/2014 (IW2)							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
82846	\$2,449.42	\$0.00	\$2,449.42	N/A	80	\$0.00	Refer to Analysis

Copy to:

██████████  
 ██████████  
 ████████████████████

Copy to:

██  
 ██  
 ██