MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 29, 2015

[redacted]

IBR Case Number:	CB14-0001845	Date of Injury:	12/23/2010
Claim Number:	[redacted]	Application Received:	12/01/2014
Claims Administrator:	[redacted]		
Date Assigned:	2/26/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, 82145-59, 82055 and 82570		

[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 $90.47 in additional reimbursement for a total of $340.47. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $340.47 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 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]

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 Laboratory CPT Services; 82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, 82145-59, 82055 & 82570 performed on 06/26/2013.**
- 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 Claims Administrator reimbursement rational: "The documentation does not support the level of service."
- As defined by the US Centers for Medicare and Medicaid Services (CMS), HCPCS G0431 is defined as follows: G0431 (Drug screen, qualitative; multiple drug classes by **high complexity test method** (e.g., immunoassay, enzyme assay), per patient encounter) will be used to report more complex testing methods, such as multi-channel chemistry analyzers, where a more complex instrumented device is required to perform some or all of the screening tests for the patient. Note that the descriptor has been revised for CY 2011. This

code may only be reported if the drug screen test(s) is classified as CLIA high complexity test(s) with the following restrictions:
    - May only be reported when tests are performed using instrumented systems (i.e., durable systems capable of withstanding repeated use).
    - CLIA waived tests and comparable non-waived tests may not be reported under test code G0431; they must be reported under test code G0434.
    - CLIA moderate complexity tests should be reported under test code G0434 with one (1) Unit of Service (UOS).
    - G0431 may only be reported once per patient encounter.
- As defined by the US Centers for Medicare and Medicaid Services (CMS), G0434 is defined as follows: HCPCS G0434: (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) will be used to report **very simple testing methods**, such as dipsticks, cups, cassettes, and cards, that are interpreted visually, with the assistance of a scanner, or are read utilizing a moderately complex reader device outside the instrumented laboratory setting (i.e., non-instrumented devices). This code is also used to report any other type of drug screen testing using test(s) that are classified as Clinical Laboratory Improvement Amendments (CLIA) moderate complexity test(s), keeping the following points in mind:
    - Includes, qualitative drug screen tests that are waived under CLIA as well as dipsticks, cups, cards, cassettes, etc. that are not CLIA waived.
- The Provider states the "medical office holds a Clinical Laboratory License as a high complexity laboratory (effective 06/28/10)." The analyzer utilized to perform the assays is an "Olympus AU400 and AU640." According to the manufacturer, this dual analyzer is classified as a "**high complexity**" unit.
- Moderate v. High complexity as defined by Centers for Disease Control Clinical Laboratory Improvement Amendments (CLIA), "Clinical laboratory test systems are assigned a moderate or high complexity category on the basis of seven criteria given in the CLIA regulations. For commercially available FDA-cleared or approved tests, the test complexity is determined by the FDA during the pre-market approval process. For tests developed by the laboratory or that have been modified from the approved manufacturer's instructions, the complexity category defaults to high complexity per the CLIA regulations, See 42 CFR 493.17.
- Lab Report supports the reporting of a high complexity (computerized) testing.
- Due to the high complexity of the toxicology test performed; results report a computerized quantitative measure of each drug screened, and the fact that the computer system utilized to determine the results is not CLIA waved and the Provider's laboratory is licensed, the code assignment G0434 is incorrect.
- A similar code historically assigned for CPT Codes 82145, 83925, 83925-59,83992, 83840, 82520, 80154, & 82205 is G0431, "multiple drug classes by high complexity test method." Given the documentation provided and the aforementioned guidelines discussed, it is recommended that the Disputed Codes: 82145, 83925, 83925-59,83992, 83840, 82520, 80154, & 82205 be reimbursed as code G0431 in accordance with Title 8, California Code of Regulations, §9789.50 Laboratory Fee Schedule.
- The last two Disputed Codes 82055 and 82570 are not inclusive to G0431 and it is recommended that these two codes be reimbursed separately in accordance with Title 8, California Code of Regulations, §9789.50 Laboratory Fee Schedule.

- Contractual Agreement received for review shows a 5% discount to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 82145, 82205, 80154, 82520, 83840, 83992, 83925, 83925-59, 82145-59, 82055 & 82570

Date of Service: 8/7/2014							
Laboratory Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
G0431	$584.00	$47.48	$536.52	N/A	1	$113.09	Reimbursement = $65.61 Due to Provider
82055	N/A	N/A	N/A	N/A	N/A	$16.81	Recommended Reimbursement
82570	N/A	N/A	N/A	N/A	N/A	$8.05	Recommended Reimbursement

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