

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 21, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001720	Date of Injury:	06/30/2009
Claim Number:	[REDACTED]	Application Received:	09/25/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	03/30/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	G6040 (changed from 80320)		

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 \$195.00 for the review cost. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$195.00** 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, MD, MPH
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
- National Correct Coding Initiatives
- Clinical Laboratory 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 full remuneration for G6040 Drug & Ethanol Analyses performed on **03/30/2015**.
- The Claims Administrator denied reimbursement for G6040 with the following rationale: “No separate payment was made because the value of the service is included within the value of another service performed on the same day.”
- **CCR § 9789.50 (a) Pathology and Laboratory:** Effective for services after January 1, 2004, the maximum reasonable fees for pathology and laboratory services shall not exceed one hundred twenty (120) percent of the rate for the same procedure code in the CMS' Clinical Diagnostic Laboratory Fee Schedule, as established by Sections 1833 and 1834 of the Social Security Act (42 U.S.C. §§ 1395l and 1395m) and applicable to California.
- 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.
- Provider states “Center holds a CLIA Certificate of Accreditation, #, (not a CLIA certificate waiver).” A copy of the Provider’s Laboratory license was submitted and reviewed.

- HCPCS code **G6040 Alcohol (ethanol); any specimen except breath (including ethyl alcohol)**, is not inclusive of G0431 testing and is separately reimbursable in accordance with Title 8, CCR § 9789.50 Laboratory Fee Schedule.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for G0431 and full reimbursement is indicated for G6040.**
- EOR dated 10/01/2015 was submitted after Provider filed this dispute showing a payment for G6040 was submitted in the amount of \$17.64. Therefore, no further reimbursement is owed for G6040. However, Claims Administrator is responsible for the IBR application fee of \$195.00 to be reimbursed to the Provider.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: G6040

Date of Service: 03/30/2015						
Clinical Laboratory						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
G6040	\$30.00	\$0.00	\$30.00	1	\$17.64	Refer to Analysis

Copy to:

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

Copy to:

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