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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 2, 2015

[redacted]

IBR Case Number:	CB15-0002060	Date of Injury:	08/10/2011
Claim Number:	[redacted]	Application Received:	11/09/2015
Claims Administrator:	[redacted]		
Date(s) of service:	07/09/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	G0431		

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 and $89.77 in additional reimbursement for a total of $284.77. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$284.77** 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
- PPO Contract: 95%

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 additional remuneration for G0431 Urine Drug Screen for date of service **07/09/2015**.
- The Claims Administrator reimbursed G0431 as G0434 based on "the procedure code billed does not accurately describe the services performed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing"
- Submitted Contractual Agreement indicates "95%" OMFS.
- **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.

- As defined by the US Centers for Medicare and Medicaid Services (CMS 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.
- 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 <u>instrumented</u> device is required to perform some or all of the screening tests for the patient**. 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.
- **Lab Report for date of service reflects high complexity ("instrumented") <u>computerized quantitative</u>** analysis. As such, the re-assigned G0434 Code is incorrect.
- Provider states "Center holds a CLIA Certificate of Accreditation, #, (not a CLIA certificate waiver)." A copy of the Provider's Laboratory license was submitted for review.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for G0431.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: G0431

Date of Service: 07/09/2015							
Laboratory Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
G0431	$200.00	$23.04	$95.71	N/A	1	$112.81	**$89.77 Due Provider Refer to Analysis**

Copy to:

[redacted]

Copy to:

[redacted]