

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 19, 2015



IBR Case Number:	CB15-0000345	Date of Injury:	10/7/2013
Claim Number:	[REDACTED]	Application Received:	03/11/2015
Claims Administrator:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	80152, 80174, 80184, 83925, 83789, 82205, 80154, 80160, 80166, 83840, 84022, 80182, 80500, 82003, 82055, 82570, 81002, 82649, 82646, 83805		



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 \$119.04 in additional reimbursement for a total of \$314.04 A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$314.04 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
Chief Coding Reviewer

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
- National Correct Coding Initiatives
- Other: OMFS Physicians 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 is seeking additional reimbursement for the billed laboratory codes: 80152, 80174, 80184, 83925, 83789, 82205, 80154, 80160, 80168, 83840, 84022, 80182, 80500, 82003, 82055, 82570, 81002, 82649, 82646 and 83805.**
- Provider was reimbursed \$30.35 and is seeking additional reimbursement of \$700.65.
- CPT 80500: Documentation did not substantiate the billed code 80500. A written report was not submitted as part of the documentation. Reimbursement is not recommended for CPT 80500.
- CPT codes 82055, 82570 and 81002: Claims Administrator reimbursed the provider based on the Pathology and Laboratory OMFS. No additional reimbursement recommended.
- CPT codes: 80152, 80174, 80184, 83925, 83789, 82205, 80154, 80160, 80168, 83840, 84022, 80182, 82003, 82649, 82646 and 83805.
- Provider's rationale indicated "tests were performed per physician's orders." The Physician's Order was not submitted as part of the IBR documentation.
- The above mentioned codes do not warrant separate reimbursement for each billed code. The documentation was lacking clinical rationale, Physicians Orders or chart notes to support the necessity for the 16 disputed drug test codes.
- Based on the tests performed, results and testing method (LC/MS/MS) reimbursement is recommended based on HCPCS G0431.

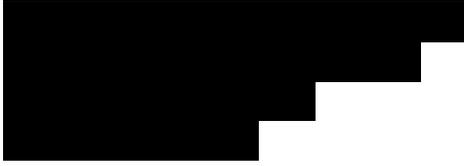
- HCPCS G0431: Drug screen qualitative; multiple drug classes by high complexity test method (e.g. immunoassay, enzyme assay), per patient encounter.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code: G0431

Date of Service: 9/18/2014							
Laboratory Service							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
80500	\$50.75	\$0.00	\$50.75	N/A	1	\$0.00	DISPUTED SERVICE- See analysis
82055	\$20.50	\$17.69	\$2.81	N/A	1	\$17.69	DISPUTED SERVICE- See analysis
82570	\$9.75	\$8.47	\$1.25	N/A	1	\$8.47	DISPUTED SERVICE- See analysis
81002	\$5.00	\$4.19	\$0.81	N/A	1	\$4.19	DISPUTED SERVICE- See analysis
G0431 (80152, 80174, 80184, 83925, 83789, 82205, 80154, 80160, 80168, 83840, 84022, 80182, 82003, 82649, 82646 and 83805.	\$645.00	\$0.00	\$645.00	N/A	1	\$119.04	DISPUTED SERVICE- See analysis. Reimbursement recommended for CPT G0431.

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