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

February 17, 2016

[redacted]

IBR Case Number:	CB16-0000112	Date of Injury:	03/29/2011
Claim Number:	[redacted]	Application Received:	01/25/2016
Claims Administrator:	[redacted]		
Date(s) of service:	12/29/2014		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	G6045, G6046, and G6056		

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 $89.99 in additional reimbursement for a total of $284.99. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $284.99 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]

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
- Negotiated contracted rates: 5% PPO Discount
- National Correct Coding Initiatives

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 dissatisfied with denial of codes G6045, G6056 and G6056 performed on 12/29/2014.
- Claims Administrator reimbursed $23.10 indicating “Procedure code billed does not accurately describe the services performed”
- 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.
- High complexity of the toxicology test performed; results reported a computerized measure of each drug screened which the Provider did submit.
- Quantitative Levels: A drug can be detected in a donor's sample and still be reported as negative. A laboratory has what is called, "cutoff levels". These levels are designed to screen out some over-the-counter pharmaceuticals or vitamins.
- Due to the complexity of the toxicology test performed, the laboratory services shall be paid in accordance with HCPCS code G0431.

- Upon review of Centers for Medicare & Medicaid Services (CMS) guidelines, HCPCS code G0431 is reported with only one unit of service regardless of the number of drugs screened. The testing described by G0431 includes all CLIA high complexity urine drug screen testing as well as any less complex urine drug screen testing performed at the same patient encounter.
- Based on information reviewed, reimbursement of G0431 is warranted.
- PPO contract received shows a 5% PPO discount to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes G6045, G6056 and G6056

Date of Service: 12/29/2014						
Pathology and Laboratory Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
G0431	$195.62	$23.10	$133.39	1	$113.09	**$89.99 Due to Provider**

[redacted]

[redacted]

[redacted]

[redacted]