

**MAXIMUS FEDERAL SERVICES, INC.**

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

---

**Independent Bill Review Final Determination Reversed**

2/21/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 2/26/2013 – 2/26/2013  
MAXIMUS IBR Case: CB13-0000320

Dear [REDACTED],

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/26/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$965.07, for a total of \$1,300.07.**

**Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:**

The following evidence was used to support the decision:

- 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 or negotiated contract: OMFS
- Other: California Workers' Compensation pharmacy fee schedule

### Supporting Analysis:

The dispute regards the denial of reimbursement for pharmaceutical supplies for date of service 2/26/2013. The provider billed a total of \$58,900.00 for five medications using NDC 2991140706 (Hydromorphone), 38779056104 (Clonidine), 38779196806 (Sufentanil), 18860072010 (Prialt) and 63370004035 (Bupivacaine). The Claims Administrator denied reimbursement for the five medications indicating " Upon re-evaluation of your bill it has been determined that no allowance is due. These medications are included in the facility allowance. No payment is due."

The medications were prescribed for an intrathecal pump fill and adjustment. The medications were ordered by the Provider and delivered to the Provider's office. The worker's pump was refilled and reprogrammed to deliver the medications: Hydromorphone, Clonidine, Sufentanil, Prialt and Bupivacaine on date of service 2/26/2013, at the surgery center.

The Provider has stated that medications are ordered and shipped to the Provider's office. The actual pump refill is performed at the surgery center to ensure the safety of the patient. Per the Provider, the types of medications being administered have a high potential for complications or resulting in the need for emergency services not available in the Provider's office.

Based on the documentation submitted by the Provider, the medications were not billed by the surgery center. The re-evaluation decision by the Claims Administrator indicating the reimbursement for the medications was included in the surgery center's allowance was not correct. Therefore, reimbursement is warranted for the medications billed by the Provider.

The Claims Administrator should have reimbursed the Provider for the medications billed using NDC 62991140706 (Hydromorphone), 38779056104 (Clonidine), 38779196806 (Sufentanil), 18860072010 (Prialt) and 63370004035 (Bupivacaine) . The total quantity per NDC was determined based on the quantity of medication (mg or mcg) per ml for a total quantity of 40 ml. The NDCs and Metric Decimal Units (MDU) were entered into the Workers' Compensation Pharmacy Compound Prescription Calculator. The Provider submitted the documented paid cost for the pharmaceuticals. The documented paid cost for the Sufentanil and Hydromorphone were less than the OMFS Pharmacy Compound Prescription calculator cost, therefore, reimbursement for Sufentanil and Hydromorphone are based on the Provider's documented paid costs.

The additional reimbursement of \$965.07 is warranted per the Workers' Compensation pharmacy fee schedule.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
62991140706	.56 gm	\$26,145.00	\$95.00	\$0.00	\$95.00	OMFS
38779056104	.056 gm	\$1,657.11	\$10.88	\$0.00	\$10.88	OMFS
38779196806	.012 gm	\$1,207.25	\$260.00	\$0.00	\$260.00	OMFS
18860072010	.93 ml	\$643.81	\$593.65	\$0.00	\$593.65	OMFS
63370004035	.28 gm	\$154.53	\$5.54	\$0.00	\$5.54	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for NDC 62991140706, 38779056104, 38779196806, 18860072010 and 63370004035 (\$965.07) for a total of \$1,300.07.

***The Claims Administrator is required to reimburse the provider \$1,300.07 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).***

Sincerely,

██████████, RHIT

Copy to:

██  
██  
██  
██

Copy to:

██  
██  
██