

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

7/31/2014

[REDACTED]
 [REDACTED]
 [REDACTED]

IBR Case Number:	CB13-0000653	Date of Injury:	8/2/1995
Claim Number:	[REDACTED]	Application Received:	10/28/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	5/6/2013 – 5/6/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	38779073105		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/27/2014, 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 \$43.44, for a total of \$378.44.**

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 (OMFS) or negotiated contract: OMFS
- Other: OMFS Pharmacy

Supporting Analysis:

The dispute regards the denial of a pharmaceutical billed as NDC #38779-0731-05. The initial explanation of review (EOR) indicated the billed compounded drug NDC was denied with the following explanation "Prescription is incomplete. Missing/incomplete/invalid. Compound drug; please resubmit invoice of documented paid cost as defined under AB378, Chapter 545, Section 139.3, 139.31 and LC5307.1." The second and/or final EOR indicated a denial of the NDC with the following explanation "Pursuant to 5307.1, they need to submit documented paid costs if the compounded drug is dispensed by a physician, the maximum reimbursement shall not exceed 300 percent of documented paid costs, but in no case more than twenty (\$20) above documented paid costs."

The medication was 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 medication: Dilaudid for date of service 5/6/2013.

Per Labor Code Section 5307(e)(2), any compounded drug product shall be billed by the compounding pharmacy or dispensing physician at the ingredient level, with each ingredient identified using the applicable National Drug Code (NDC) of the ingredient and the corresponding quantity, and in accordance with regulations adopted by the California State Board of Pharmacy. Ingredients with no NDC shall not be separately reimbursable. The ingredient-level reimbursement shall be equal to 100 percent of the reimbursement allowed by the Medi-Cal payment system and payment shall be based on the sum of the allowable fee for each ingredient plus a dispensing fee equal to the dispensing fee allowed by the Medi-Cal payment systems. If the compounded drug product is dispensed by a physician, the maximum reimbursement shall not exceed 300 percent of documented paid costs, but in no case more than twenty dollars (\$20) above documented paid costs.

MAXIMUS requested a copy of the invoice and/or proof of paid costs. The Provider submitted an Invoice for Hydromorphone (NDC 38779-0731-05), strength 5mg/ml, volume 20ml and invoice price of \$35.00. The documented paid costs plus \$20.00 is \$55.00. The Workers' Compensation fee schedule allowance is \$43.44. The reimbursement for the NDC 38779-0731-05 is recommended based on the Workers' Compensation pharmacy fee allowance of \$43.44

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
38779073105	.1gm	\$5,500.00	\$43.44	\$0.00	\$43.44	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 code 38779073105 (\$43.44) for a total of \$378.44.

The Claims Administrator is required to reimburse the provider \$390.00 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,

[Redacted signature]

[Redacted text]

[Redacted text]