

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

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Fax: (916) 605-4280

Independent Bill Review Final Determination Reversed

4/28/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 4/9/2013 – 4/9/2013
MAXIMUS IBR Case: CB13-0000669

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/2/2013, 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 \$26.98, for a total of \$361.98.**

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 payment amount for pharmaceutical supplies for date of service 4/9/2013. The provider billed a total of \$1,040.00 for a medication using NDC 62991140305 (Morphine Sulphate). The Claims Administrator paid \$1.00 for the medication with the explanation "Upon re-evaluation of your bill it has been determined that it was previously paid correctly. No additional allowance is due. The medication is price per gram per the DWC Pharmacy Fee Schedule. 20mg/ml times 20 (refill quantity) = 400 mg /0.001 = .4 gm."

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 medication: Morphine

The total quantity per NDC was determined based on the quantity of medication (mg or mcg) per ml for a total quantity of 20 ml. The pharmacy order indicated a prescription for Morphine Sulfate 20mg/ml. The NDC and Metric Decimal Units (MDU) were entered into the Workers' Compensation Pharmacy Compound Prescription Calculator.

MAXIMUS requested a copy of the PPO contract. The PPO contract submitted was not complete. The PPO contract indicated the allowance for Workers' Compensation services and supplies shall be reimbursed at the lesser of the PPO Fee Schedule or California Division of Workers' Compensation Official Medical Fee Schedule. A copy of the PPO fee schedule was not received as part of the documentation submitted. The recommended allowances and/or reimbursements were calculated based on the Official Medical Fee Schedule (OMFS).

The additional reimbursement of \$26.98 is warranted per the Workers' Compensation Pharmacy Compound Prescription Calculator

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
62991140305	.4gm	\$1,039.00	\$27.98	\$1.00	\$26.98	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 62991140305 (\$26.98) for a total of \$361.98.

The Claims Administrator is required to reimburse the provider \$361.98 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:

State Compensation Insurance Fund

[REDACTED]
[REDACTED]
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[REDACTED]
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