



## Supporting Analysis:

5307.1(e)(1) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003, except as otherwise provided in this subdivision.

(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.

(3) For a dangerous drug dispensed by a physician that is a finished drug product approved by the federal Food and Drug Administration, the maximum reimbursement shall be according to the official medical fee schedule adopted by the administrative director.

(4) For a dangerous device dispensed by a physician, the reimbursement to the physician shall not exceed either of the following:

(A) The amount allowed for the device pursuant to the official medical fee schedule adopted by the administrative director.

(B) One hundred twenty percent of the documented paid cost, but not less than 100 percent of the documented paid cost plus the minimum dispensing fee allowed for dispensing prescription drugs pursuant to the official medical fee schedule adopted by the administrative director, and not more than 100 percent of the documented paid cost plus two hundred fifty dollars (\$250).

(5) For any pharmacy goods dispensed by a physician not subject to paragraph (2), (3), or (4), the maximum reimbursement to a physician for pharmacy goods dispensed by the physician shall not exceed any of the following:

(A) The amount allowed for the pharmacy goods pursuant to the official medical fee schedule adopted by the administrative director or pursuant to paragraph (2), as applicable.

(B) One hundred twenty percent of the documented paid cost to the physician.

(C) One hundred percent of the documented paid cost to the physician plus two hundred fifty dollars (\$250).

The dispute regards the denial of an over the counter pharmaceutical billed as NDC 50488112901 for date of service 06/21/2013.

The Claims Administrator denied the billed pharmaceutical on the initial and final explanation of review with the following reason code/explanation:

- BHBB: Incorrect NDC, please provide correct underlying NDC
- G10: We cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible

- No additional reimbursement allowed after review of appeal/reconsideration

A letter was submitted to MAXIMUS from the Provider dated 03/19/2014, indicating the Claims Administrator reimbursed the Provider an additional amount of \$377.25 for the billed OTC medication Terocin, for date of service 06/21/2013. The additional payment by the Claims Administrator was issued after the Independent Bill Review application was received by MAXIMUS. The IBR application was received on 11/14/2013. The additional payment of \$377.25 was issued on 11/25/2013. Although, the claim was ultimately reimbursed, the Provider opted to continue with the Independent Bill Review and seek reimbursement of the IBR application fee.

During the analysis of the case, it was found that the Claims Administrator submitted a dispute to the Provider's Independent Bill Review (IBR) application on 03/26/2014 indicating Terocin lotion, provided to the injured worker on 06/21/2013, was not certified. A Utilization Review letter, dated 07/12/2013, also indicated non-certification of Terocin; date of service not specified. Further analysis found that the submitted explanation of reviews (initial and final) did not indicate that the service was denied due to non-certification. In fact, the Claims Administrator reimbursed the Provider \$377.25 on 11/25/2013 for the Terocin billed on the date of service in question, 06/21/2013. Due to the limited documentation provided, it was unclear whether or not the billed medication was certified or non-certified. Since the additional payment was reimbursed on 11/25/2013 for Terocin on date of service 06/21/2013, and the Provider wished to continue with the IBR, the disputed code/item were then reviewed based on the validity of the submitted NDC and associated documents.

The submitted documentation included a CMS – 1500 claim form documenting the NDC 50488-1129-01 and an invoice documenting the paid/cost per unit of Terocin Lotion 120ML as \$24.00.

The submitted NDC 50488-1129-01 is a valid National Drug Code (NDC). The Red Book Online product details provided the following information regarding the drug:

- Product Name: Terocin
- Active Ingredient capsaicin/menthol/methylsalicylate
- Manufacturer/Distributor: Alexso, Inc
- AWP pricing history effective 04/01/2013 package \$426.00 Unit \$3.55

The NDC is valid, however the DWC Pharmacy Fee Schedule calculator did not result in a match on the NDC provided; therefore, a fee schedule price was not available. The allowance for the billed OTC medication was determined based on LC5307.1 (e) (5), One hundred twenty percent of the documented paid cost to the physician. Reimbursement of \$28.80 is warranted for the billed NDC 50488-1129-01.

Based on the documentation submitted, reimbursement was warranted for the NDC 50488-1129-01 . The Provider indicated the disputed amount was paid in full by the Claims Administrator. Due to the disputed amount was paid in full prior to the IBR Final Determination decision the only amount due by the Claims Administrator is the IBR application fee of \$335.00

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
50488112901	1	\$28.80	\$28.80	\$377.25	\$0.00	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 50488-1129-01 (\$0.00) for a total of \$335.00.

***The Claims Administrator is required to reimburse the provider \$335.00 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]  
Chief Coding Reviewer

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[Redacted]  
[Redacted]  
[Redacted]

Copy to:

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