

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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Fax: (916) 605-4280

**Independent Bill Review Final Determination Upheld**

7/28/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB13-0000758	Date of Injury:	8/2/1995
Claim Number:	[REDACTED]	Application Received:	11/18/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	3/29/2013 – 3/29/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	62991140706		

Dear [REDACTED]

**Determination**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/28/2014, 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 upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

**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
- Other: OMFS Pharmacy Fee Schedule

**Supporting Analysis:**

The dispute regards the denial of pharmaceutical supplies for date of service 3/29/2013. The provider billed a total of \$5,500 for medication using NDC 62991140706 (Hydromorphone). The Claims Administrator reimbursed \$65.76 for the billed medication (62991140706) with the explanation "The charge has been adjusted to the scheduled allowance. Reimbursement based on California's Medi-Cal payment system. Reimbursement is for bio-equivalent generic medication dispensed."

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 (Hydromorphone) for date of service 3/29/2013.

The Medication was billed using NDC 62991140706. The documentation included a prescription, valid NDC and a Session Data Report. The Refill Administration Sheet indicated an order for Dilaudid 10mg/ml for 10ml. The Claims Administrator reimbursed the Provider for the medication based on the Workers' Compensation Pharmacy Compound Prescription Calculator. The invoice/proof of paid cost was not submitted as part of the documentation. No additional reimbursement is warranted per the billed medication under NDC 62991140706 (Hydromorphone).

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
62991140706	.1gm	\$94.49	\$65.76	\$65.76	\$0.00	OMFS

**Chief Coding Specialist Decision Rationale:**

This decision was based on medical record, explanation of review and comparison with OMFS Pharmacy Fee Schedule. This was determined correctly by the Claims Administrator and the payment of \$65.76 is upheld.

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]