

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 29, 2014

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000764	Date of Injury:	07/24/2000
Claim Number:	[REDACTED]	Application Received:	11/18/2013
Claims Administrator:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	NDC 62991140706 & NDC 38779196806		

Dear [REDACTED]:

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

[REDACTED]
[REDACTED]

cc: [REDACTED]
[REDACTED]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- 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
- Negotiated contracted rates: N/A
- Red Book
- Other: OMFS Pharmacy Fee Schedule

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE:** The provider is dissatisfied with the reimbursement of \$9425.49 for a compounded drug product billed as NDC 62991140706 and 38779196806.
- **Initial review indicated a reimbursement of \$9425.49** for NDC 38779196806 and 62991140706.
- Per Labor Code Section 5307.1 (e) (2) compounded drug products are to be billed by the pharmacy or dispensing physician at the ingredient level by National Drug Code (NDC) and quantity. 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 allowed by MEDI-CAL. If dispensed by a physician, the maximum reimbursement shall not exceed 300 percent of documented paid costs, but no more than twenty dollars above documented paid costs.
- For any pharmacy goods dispensed by a physician not subject to the above, the maximum reimbursement to a physician for pharmacy goods dispensed by the physician shall not exceed any of the following: the allowed amount in the Official Medical Fee Schedule, one hundred twenty percent of the documented paid cost to the physician, or one hundred percent of the documented paid cost to the physician plus two hundred fifty dollars.
- 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 medications: Sufenta and Dilaudid for date of service 05/21/2013.
- The invoice for the compounded drug product indicated a paid cost of \$250.00.

- Reimbursement by the Claims Administrator exceeded the documented paid cost; therefore, no additional reimbursement is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code NDC 62991140706 and NDC 38779196806

Date of Service: 5/21/2013						
Compounded Drug Product						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
62991140706 & 38779196806	\$21600.00	\$9425.49	\$12174.51	N/A	\$ 270.00	DISPUTED SERVICE: No additional reimbursement warranted.

Copy to:

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

Copy to:

[REDACTED]
 [REDACTED]
 [REDACTED]