

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 16, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-0000125	Date of Injury:	11/29/1997
Claim Number:	[REDACTED]	Application Received:	01/29/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	06/11/2013 – 06/11/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	NDC's 38779-0388-05; 62991-1403-07; and 38799-0561-04		

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: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$195.00 for the review cost and \$75.45 in additional reimbursement for a total of \$270.45. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$270.45** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. 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,

Paul Manchester, M.D., M.P.H.  
Medical Director

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
- Red Book
- Official Medical 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: Provider seeking remuneration for NDC's 38779-0388-05; 62991-1403-07; and 38799-0561-04 compound medication for date of service 06/11/2013.**
- Claims Administrator denied reimbursement based on the following rationale: “exceeds the Official Medical Fee Schedule Allowance. The charge has been adjusted to the scheduled allowance.
- Red Book Indicates the following:
  - NDC 38779038805 Baclofen **Powder**
  - NDC 38779056104 Clonidine Hydrochloride **Powder**
  - NDC 62991140307 Morphine Sulfate **Powder**
- CMS 1500 form indicates the following:
  - NDC 38779038805 Baclofen 2 units
  - NDC 38779056104 Clonidine 2 units
  - NDC 62991140307 Morphine S04 400 units
- CMS 1500 form reflects J codes utilized to determine the number of billed units. J Codes do not adequately describe compounded medications as J codes typically represent pre-mixed medications with a standard unit of measure. Conversely, Compounded Medication utilizing NDC codes represent the actual substance(s) utilized with the NDC dictating unit of measure.
- Pharmacological documentation indicates the powders were compounded in a pump volume of 20 mls. The **powder** (actual) ingredients are as follows:
  - Baclofen 100mcg/ml
  - Clonidine HCL 100mcg/ml
  - Morphine Sulfate 20 mg/ml
- **Labor Code 5307.1. (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.
- The (actual) **ingredient level of powder** is as follows:
  - Baclofen 100mcg/ml = 0.0001g
  - Clonidine HCL 100mcg/ml = 0.0001g
  - Morphine Sulfate 20 mg/ml = 0.02000000g
- **Volume 20 ml:**
  - Baclofen 100mcg/ml = 0.002g of powder utilized
  - Clonidine HCL 100mcg/ml = 0.002g of powder utilized
  - Morphine Sulfate 20 mg/ml = 0.4g of powder utilized

- 06/07/2013 invoice presented to IBR indicates the Provider pre-paid for medication for date of service 6/11/2013. The invoice reflects the following:
  - NDC 38779038805 Baclofen **\$30.00**
  - NDC 38779056104 Clonidine Hydrochloride **\$20.00**
  - NDC 62991140307 Morphine Sulfate **\$25.00**
  - Total: \$75.00
- Based on the documentation and guidelines, reimbursement is indicated for NDC 38779-0524-04 & NDC 38779-0673-04 **Pursuant to Labor Code § 5307.1 (3) (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 (Injection Fee \$4.46 Injection fee.)

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: NDC's 38779-0388-05; 62991-1403-07; and 38799-0561-04**

<b>Date of Service:</b> 10/02/2014						
<b>Pharmacy</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
NDC's 38779-0388-05; 62991-1403-07; and 38799-0561-04	\$942.26	\$19.01	\$942.00	0.002g 0.002g 0.04g	\$94.46	<b>Compounded Medication</b> OMFS 120% + Injection Fee \$4.25 – Reimbursed Amount = <b>\$75.45 Due Provider</b>

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