

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review

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8/2/2013

**Independent Bill Review Final Determination Reversed**

[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 1/3/2013 – 1/3/2013  
MAXIMUS IBR Case: CB13-0000016

Dear [REDACTED],

**Determination**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 6/6/2013, 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 \$28,350.00, for a total of \$28,685.00.**

**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: Workers' compensation pharmacy fee schedule and California Business and Professions code 4194

**Supporting Analysis:**

The dispute regards the denial of payment for pharmaceutical supplies for date of service 1/03/2013. The provider billed for two medications using NDC 62991140706 (Hydromorphone) and 38779196806 (Sufentanil). The Claims Administrator denied the reimbursement of the medications indicating "These medications are included in the facility allowance. No payment is due."

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 medications: Sufentanil and Hydromorphone on date of service 1/03/2013 at the surgery center.

The California Business and Professions Code Section 4194 states "No Schedule II controlled substance shall be dispensed in the clinic." Both Sufentanil and Hydromorphone are Schedule II drugs. The Provider has stated that medications are ordered and shipped to the Provider's office. The actual pump refill is performed at the surgery center to ensure the safety of the patient. The types of medications being administered have a high potential for complications or resulting in the need for emergency services not available in the Provider's office.

On 6/6/2013 MAXIMUS requested the Claims Administrator provide a copy of the explanation of review or proof of payment to the facility for the medications: NDC 62991140706 and NDC 38779196806. The requested information was not received. Therefore, the review was based on the documentation received from the Provider.

Based on the review of the documentation received, the denial of reimbursement by the Claims Administrator was inappropriate. The Claims Administrator should have reimbursed the Provider for the medications billed using NDC 62991140706 and 38779196806. The reimbursement is based on the Workers' Compensation pharmacy fee schedule.

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
NDC 62991140706	105	\$23,100.00	\$23,100.00	\$0.00	\$23,100.00	OMFS
NDC 38779196806	210	\$5,250.00	\$5,250.00	\$0.00	\$5250.00	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 38779196806 and 62991140706 (\$28,350.00) for a total of \$28,685.00.

***The Claims Administrator is required to reimburse the provider \$28,685.00 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,

, RHIT

Copy to:



Copy to:

Division of Workers' Compensation Medical Unit  
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