

**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**

December 24, 2014

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB13-0000914	Date of Injury:	08/30/2006
Claim Number:	[REDACTED]	Application Received:	12/20/2013
Claims	[REDACTED]		
Dates(s) of service:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	(J3490) - NDC# 49452003202, NDC# 38779052409		

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.

Case Assigned: 11/18/2014

**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 \$335.00 for the review cost and \$736.54 in additional reimbursement for a total of \$1071.54. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1071.54 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,

[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
- Negotiated contracted rates: Not available
- CCR 9789.40
- Other: Worker's Compensation 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:** Additional reimbursement for J3490 (NDC# 49452003202, NDC# 38779052409)
- Based on review of CCR 9789.40, we find additional payments are warranted.
- As described in 9789.40, the maximum reasonable fee for pharmaceuticals and pharmacy services rendered after January 1, 2004 is 100% of the reimbursement prescribed in the relevant Medi-Cal payment system, including the Medi-Cal professional fee for dispensing. In this case, both NDC 38779052409 and 49452003202 are represented. Absent evidence of a contractual agreement, other means to determine an allowance are contraindicated.
- Employing the California Worker's Compensation Pharmacy Fee Schedule with NDC 49452003202 and 38779052409 and Metric decimal Units of .8 and .0002, an additional reimbursement of \$736.54 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code J3490 with NDC#'s 49452003202 and 38779052409

<b>Date of Service:</b> Click to enter date.							
Physician/Practitioner/Assistant Surgeon.							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
J3490	\$ 772.80	\$ 36.26	\$ 736.54	N/A	Percent reduction N/A	\$ 772.80	<b>DISPUTED SERVICE:</b> Additional reimbursement of \$736.54.

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