

MAXIMUS FEDERAL SERVICES, INC.

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

Independent Bill Review Final Determination Reversed

9/15/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000927	Date of Injury:	7/27/2004
Claim Number:	[REDACTED]	Application Received:	12/23/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	8/13/2013 – 8/13/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	38779073105, 38779056104, 38779196806 and 18860072210		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/28/2014, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$964.81, for a total of \$1,299.81.**

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: California Workers' Compensation pharmacy fee schedule

Supporting Analysis:

Per Labor Code Section 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. (3) For a dangerous drug dispensed by a physician that is a finished drug product approved by the federal Food and Drug Administration, the maximum reimbursement shall be according to the official medical fee schedule adopted by the administrative director.

The dispute regards the denial for a compounded drug product billed as NDC: 38779073105(Dilaudid); 38779056104 (Clonidine); 38779196806 (Sufenta); and the denial of reimbursement for pharmaceutical billed with NDC 18860072210 (Prialt).

The initial and final explanation of reviews (EOR) provided the following explanations for the denial of the compounded drug product and Prialt:

- The place of service where the medication(s) were administered was a Surgery Center. The medications administered were an integral part of the service provided at the ASC, therefore should be billed by the ASC. The medications billed: dilaudid; clonidine and sufenta are identified by Medicare as a Status Indicator "N", therefore per CCR 9789.32, the medications are not separately reimbursable. Per the Medicare website: Status indicator N-items and services packaged into payment for other services. Therefore, there is no separate APC payment.
- This code is either not valid or not available in the California Fee Schedule
- The Official Medical Fee Schedule does not list this code. No payment is being made at this time. Please resubmit your claim with the OMFS code(s) that best describe the service(s) provided and your supporting documentation.

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: Hydromorphone (Dilaudid); Clonidine; Prialt; and Sufentanil (Sufenta) on date of service 8/13/2013, at the surgery center.

In review of the submitted Surgery Center Claim for date of service 8/13/2013, the medications were not billed by the surgery center. Therefore, reimbursement is warranted for the medications billed by the Provider.

The Intrathecal Pump Maintenance and Administration Record documented an order for Hydromorphone HCL 14 mg/ml and Sufentanil 300 mcg/ml, Clonidine 1400 mcg/ml, and Prialt 100 mcg/ml for a total volume of 25 ml. Although the Administration Record documented .63ml of the

1 ml vial of Prialt was used; the Prialt medication is purchased as a single use vial and reimbursement should be based on the allowance for the 100mcg/ml vial under NDC 18860072210.

The documented paid cost/invoice for the compounded drug product was submitted as part of the documentation. The documented paid cost for the compounded drug product (Hydromorphone, Sufentanil, and Clonidine) for the pump refill was documented on the invoice as \$301.00. Reimbursement is warranted for the compounded drug product based on the paid cost (\$301.00) plus \$20.00.

The billed medication Prialt was not included in the compounded drug product and is priced separately, based on the DWC Pharmacy Fee Schedule. Reimbursement is warranted based on one unit of NDC 18860072210 (100mcg/ml Single Use Vial).

The additional reimbursement of \$964.81 is warranted for the billed NDC codes: 38779073105 (Dilaudid); 38779056104 (Clonidine); 38779196806 (Sufenta) and 18860072210 (Prialt).

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
Compounded Drug Product	1	\$19,644.42	\$321.00	\$0.00	\$321.00	OMFS
18860072210 Prialt	1	\$643.81	\$643.81	\$0.00	\$643.81	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 codes: 38779073105; 38779056104; 3877916806 and 18860072210 (\$964.81) for a total of \$1,299.81.

The Claims Administrator is required to reimburse the provider \$1,299.81 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
Chief Coding Reviewer

Copy to:

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[REDACTED]
[REDACTED]
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