MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Independent Bill Review Final Determination Upheld

10/14/2014

[redacted]

IBR Case Number:	CB13-0000956	Date of Injury:	09/01/2003
Claim Number:	[redacted]	Application Received:	12/24/2013
Claims Administrator:	[redacted]		
Date(s) of service:	04/18/2013 and 05/08/2013		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	J3490 (NDC 49452003202 and 18860072010)		

Dear [redacted]:

Determination
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 6/17/2014, 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 upheld.** This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

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
- Other: Official Medical Fee Schedule, Labor Code 5307.1

ANALYSIS AND FINDINGS:

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

- **ISSUE IN DISPUTE: Code J3490 (NDC 49452003202 and 18860072010) is under review as it was denied in full (or part) for REIMBURSEMENT.**
- Pursuant to 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.**
- The Provider billed for a compounded drug product (Fentanyl and Prialt), the medication was administered and dispensed in the office for an Intrathecal Drug Delivery System (IDDS) pump refill.
- The initial and final review for all dates of service (04/18/2013 and 05/08/2013) reimbursed $0.00 for the billed compounded drug with the following explanation: We cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible. (please submit copy of invoice)
- The documented paid cost/invoice for the billed medication was not submitted as part of the original documentation.
- MAXIMUS requested a copy of the invoice and/or proof of paid costs. The Provider did not submit the requested information and indicated in a response to MAXIMUS "Pharmacy invoicing pricing will not be provided."
- The documented paid costs are necessary to determine reimbursement. The Claims Administrator requested the documentation in order to determine appropriate reimbursement; the requested information was not supplied. Due to the lack of the requested documentation, reimbursement is not warranted.
- The table below describes the pertinent claim line information.
- **DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement for the compounded drug product is not warranted.**

Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amount	Notes
Date of Service 04/18/2013 and 05/08/2013 Pharmacy						
49452003202/ 18860072010	**$1711.20**	**$0.00**	**$1711.20**	**0.08 gm/ 0.1 mg**	**$0.00**	**DISPUTED SERVICE – See analysis**
49452003202/ 18860072010	**$1711.20**	**$0.00**	**$1711.20**	**0.08gm/ 0.1 mg**	**$0.00**	**DISPUTED SERVICE – See analysis**

Determination: UPHOLD

Chief Coding Specialist Decision Rationale:
This decision was based on supplied medical record and comparison with OMFS Pharmacy Fee Schedule. This was determined correctly by the Claims Administrator and the payment of $0.00 is upheld.

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,

[redacted]
Chief Coding Reviewer

Copy to:
[redacted]

Copy to:
[redacted]