

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 22, 2014

[REDACTED]  
[REDACTED]  
[REDACTED]

|                              |  |                              |            |
|------------------------------|--|------------------------------|------------|
| <b>IBR Case Number:</b>      | CB13-0000958   | <b>Date of Injury:</b>       | 09/14/2001 |
| <b>Claim Number:</b>         | [REDACTED]   | <b>Application Received:</b> | 12/24/2013 |
| <b>Claims Administrator:</b> | [REDACTED]   | <b>Assignment Date:</b>      | 10/29/2014 |
| <b>Provider Name:</b>        | [REDACTED]   |                              |            |
| <b>Employee Name:</b>        | [REDACTED]   |                              |            |
| <b>Disputed Codes:</b>       | J3490 (NDC 38779052409, 49452003202 and 62991142202) |                              |            |

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.**

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]  
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
- Official Medical Fee Schedule
- Red Book
- Other: OMFS Pharmacy Fee Schedule, LC 5307.1

## 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 is dissatisfied with the reimbursement of \$0.00 for a billed compounded drug product (NDC38779052409, 49452003202 and 62991142202).
- 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 ██████████ 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 ██████████ 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 initial and final review reimbursed \$0.00 for the compounded drug product with the following explanation: Per AB 378 (3) (a) Physicians are to be paid at the lesser of 300% of the physician's documented paid cost or documented paid cost + \$20. Please provide invoice and cancelled checks for PAID cost proof.
- The Provider is billing for a compounded drug product (Fentanyl, Bupivacaine and Clonidine), the medications were administered and dispensed in the office for an Intrathecal Drug Delivery System (IDDS) pump refill.

- The documented paid cost/invoice for the billed medications was not submitted as part of the original documentation. MAXIMUS requested a copy of the invoice and/or proof of paid costs. The requested information was not received.
- 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: Reimbursement of NDC codes 38779052409, 49452003202 and 62991142202 is not warranted.**

| Date of Service: 8/26/2013                |                 |              |                |                             |                            |  |
|---|-----------------|--------------|----------------|-----------------------------|----------------------------|--|
| Physician Services                        |                 |              |                |                             |                            |  |
| Service Code                              | Provider Billed | Plan Allowed | Dispute Amount | Units                       | Workers' Comp Allowed Amt. | Notes                                  |
| 38779052409<br>49452003202<br>62991142202 | \$2865.60       | \$0.00       | \$2,865.60     | 0.4 gm<br>0.32gm<br>0.008gm | \$0.00                     | <b>DISPUTED SERVICE</b> – See Analysis |

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