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

9/4/2014

[redacted]

IBR Case Number:	CB14-0000119	Date of Injury:	9/14/2001
Claim Number:	[redacted]	Application Received:	1/28/2014
Claims Administrator:	[redacted]		
Date(s) of service:	5/20/2013 – 5/20/2013		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	NDC 49452003202, 38779052409 and 62991142202		

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 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

Supporting Analysis:

Pursuant to Labor Code Section 5307(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 dispute regards the denial for a compounded drug product billed as NDC #49452003202, 38779052409 and 62991142202. The explanation of review (EOR) indicated the billed compounded drug NDCs were denied with the following explanation "Provide invoice showing cost for reimbursement. Per AB 378(3) (a) Physicians are to be paid at the lesser of 300% of the physician's documented paid costs or documented paid cost plus $20.00, or 120% of Medicare. Provide invoice and cancelled checks for PAID cost proof. We cannot review this service without the necessary documentation. Please submit with indicated documentation as soon as possible."

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

Validated Code	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
49452003202	$2,304.00	$0.00	$0.00	$0.00	OMFS
38779052409	$16.00	$0.00	$0.00	$0.00	OMFS
62991142202	$8.00	$0.00	$0.00	$0.00	OMFS
Compound Fee	$60.00	$0.00	$0.00	$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on medical record, explanation of review (EOR) and comparison with Official Medical Fee Schedule Pharmacy. 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,

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