

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

8/25/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000155	Date of Injury:	7/27/2004
Claim Number:	[REDACTED]	Application Received:	2/10/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	8/27/2013 – 8/27/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	38779073105, 38779056104 and 38779196806		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/7/2014, 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 \$321.00, for a total of \$656.00.**

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: OMFS Pharmacy Fee Schedule

Supporting Analysis:

Per 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 #38779073105 (Dilaudid), 38779056104 (Clonidine) and 38779196806 (Sufenta). The explanation of review (EOR) indicated the billed compounded drugs NDCs were denied with the following explanation "Based on the available information. The place of service where the medication(s) were administered was ASC. The medications administered were an integral part of the services provided at the ASC; therefore, should be billed by the ASC."

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; Clonidine; and Sufentanil on date of service 8/27/2013, at the surgery center.

The Intrathecal Pump Maintenance and Administration Record documented an order for Hydromorphone HCL 15 mg/ml and Sufentanil 300 mcg/ml and Clonidine 1500 mcg/ml for a total volume of 42 ml.

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. The OMFS Pharmacy fee schedule allowance exceeded the documented paid cost of the compound drug product. Reimbursement is warranted for the compounded drug product based on the paid cost (\$301.00) plus \$20.00.

The additional reimbursement of 321.00 is warranted for the billed NDC codes: 38779073105 (Dilaudid); 38779056104 (Clonidine); and 38779196806 (Sufenta).

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
38779073105	.6gm	\$25,027.33	\$321.00	\$0.00	\$321.00	OMFS
38779056104	.060gm					
38779196806	.012gm					

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; and 38779196806 (\$321.00) for a total of \$656.00.

The Claims Administrator is required to reimburse the provider \$656.00 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

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