

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

8/26/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000197	Date of Injury:	6/30/2003
Claim Number:	[REDACTED]	Application Received:	1/29/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	4/2/2013 – 4/2/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	NDC 62991-1403-07 and 38779-0561-04		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/17/2014, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$17.23, for a total of \$352.23.**

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: DWC Pharmacy Fee Schedule Compound Prescription Calculator

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 payment amount for a compound drug product billed using NDC 62991-1403-07 (Morphine Sulfate) and 38779-0561-04 (Clonidine HCL). The final explanation of review (EOR) indicated a prior reimbursement of \$1.05 for the compound drug product with the following explanation "4/2/2013 62991-1403-07 Morphine Sulfate powder Formula: quantity of medication per ml x refill quantity = total quantity. This total is then converted to the MDU (gm, ml, ea.). NDC #58298054510 Morphine (J2275) this medication is priced per gram per the DWC Pharmacy Fee Schedule. The provider is billing 200 units and the actual quantity used to refill the pump is 0.2grams. (1 mg = 0.001gm) 10mg/ml x 20(refill quantity) = 200 mg x 0.001 = 0.2mg. NDC 38779056104 Clonidine (J0735) this medication is priced per gram per the DWC Pharmacy Fee Schedule. The provider is billing 2 units and the actual quantity used to refill the pump is 0.003 grams. (1 mcg = 0.000001 gm) 100 mcg/ml x 20 (refill quantity) = 2000 mcg x 0.000001 = 0.002 gm."

The medication was 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 medication: Morphine and Clonidine for date of service 4/2/2013.

The Provider submitted an Invoice for: Morphine (NDC 62991-1403-07), strength 10mg/ml; and Clonidine (NDC 38779-0561-04), strength 0.1000 mg/ml, volume 20ml and invoice price of \$40.00. The documented paid costs plus \$20.00 is \$60.00. The Workers' Compensation fee schedule allowance is \$18.28 (total cost of ingredients + dispensing fee). The reimbursement for the NDC 62991-1403-07 and 38779-0561-04 is recommended based on the Workers' Compensation pharmacy fee allowance of \$18.28.

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
62991-1403-07	0.2gm	\$271.00	\$9.71	\$1.00	\$8.71	OMFS
38779-0561-04	0.002gm	\$148.45	\$0.33	\$0.05	\$0.28	OMFS
Compound Dispense Fee			\$8.24	\$0.00	\$8.24	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 code 62991-1403-07 and 38779-0561-04 (\$17.23) for a total of \$352.23.

The Claims Administrator is required to reimburse the provider \$352.23 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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