

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 24, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CM14-0001300	Date of Injury:	03/17/2000
Claim Number:	[Redacted]	Application Received:	09/08/2014
Claims	[Redacted]	Assignment Date:	11/24/2014
Dates(s) of service:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	J0735 – NCD# 38779056104; J01170 – NCD#38779073105		

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: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$250.00 for the review cost and \$8.78 in additional reimbursement for a total of \$258.78. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$258.78 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. 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]
[Redacted]

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
- Negotiated contracted rates: Contractual Agreement requested (July 29, 2014) unable to verify contractual rate, OMFS will be utilized to calculate reimbursement.
- Other: Redbook, Workers' compensation pharmacy fee schedule - Compound prescription

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:** Reimbursement of NDC# 38779073105 (J1170 Hydromorphone hydrochloride) and NDC# 38779056104 (J0735 Clonidine hydrochloride) for use in the 8840 Synchroned II B pump
- Based on review of the records, we find payment is warranted for J0735 but not J1170.
- The provider billed a total of \$1341.75 for medication using NDC's 38779073105 and 38779056104.
- CCR 9789.32 indicates no separate reimbursement is warranted for Status Indicator N items and services. The code J1170 has a Status Indicator of 'N' and no reimbursement is warranted.
- The Redbook indicates this NCD 38779056104 for Clonidine is for a 25 gm packet of powder. The medical records show 15 mg of Clonidine was utilized. This equates to .0006% of the 25 gm packet being used.
- As described in 9789.40, the maximum reasonable fee for pharmaceuticals and pharmacy services rendered after January 1, 2004 is 100% of the reimbursement prescribed in the relevant Medi-Cal payment system, including the Medi-Cal professional fee for

dispensing. In this case NDC# 38779056104 is represented. Absent evidence of a contractual agreement, other means to determine an allowance are contraindicated.

- Employing the California Worker’s Compensation Pharmacy Fee Schedule with NDC 38779056104 and a Metric decimal Unit of a TOTAL reimbursement of \$8.87 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code J1170 and J0735 is required.

Date of Service: 2/13/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
J1170	\$228.00	\$0.00	\$83.98	N/A	N/A	\$0.00	DISPUTED SERVICE: No reimbursement is warranted.
J1170 and J0735	\$1341.75	\$0.00	\$328.35	N/A	N/A	\$ 8.78	DISPUTED SERVICE: A reimbursement of \$8.78 is warranted.

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