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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 10, 2014

[redacted]

IBR Case Number:	CB14-0000653	**Date of Injury:**	05/07/1997
Claim Number:	[redacted]	**Application Received:**	04/28/2014
Claims Administrator:	[redacted]		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	J2275 (62991140305)		

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 $29.60 in additional reimbursement for a total of $279.60. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $279.60 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]

Chief Coding Reviewer

cc: [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, LC5307.1

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 compounded drug product.
- Per Labor Code Section 5307 (e) (2) compounded drug products are to be billed by the pharmacy or dispensing physician at the ingredient level by National Drug Code (NDC) and quantity. 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 allowed by MEDI-CAL. If dispensed aby a physician, the maximum reimbursement shall not exceed 300 percent of documented paid costs, but no more than twenty dollars above documented paid costs.
- For any pharmacy goods dispensed by a physician not subject to the above, the maximum reimbursement to a physician for pharmacy goods dispensed by the physician shall not exceed any of the following: the allowed amount in the Official Medical Fee Schedule, one hundred twenty percent of the documented paid cost to the physician, or one hundred percent of the documented paid cost to the physician plus two hundred fifty dollars.
- The explanation of review (EOR) indicated the billed compound drug product NDCs were denied with the following explanation “The place of service where the medication(s) were administered was an ASC. These 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: Morphine, at the surgery center.
- The Provider submitted a CMS1500 claims form for the following NDCs and HCPCS: HCPCS J2275/NDC 62991140305 x 44 units.
- The Intrathecal Pump Maintenance and Administration Record documented an order for Morphine Sulfate 20mg/ml for a total volume of 22 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 (Morphine Sulfate) for the pump refill was documented on the invoice as $25.00. The OMFS Pharmacy fee schedule allowance ($29.60). Reimbursement is warranted for the compounded drug product based on the OMFS Pharmacy Fee Schedule.
- The additional reimbursement of $29.60 is warranted for the billed NDC codes: 62991140305 (Morphine Sulfate).

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 62991140305.

Date of Service: 1/7/2014						
Compound Drug						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
6299114 0305	$ 4400.00	$ 0.00	$ 166.32	.44gm	$29.60	**DISPUTED SERVICE**: Additional allowance based on OMFS Pharmacy Fee schedule.

Copy to:

[redacted]

Copy to:

[redacted]