

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 29, 2014

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000800	Date of Injury:	07/24/1995
Claim Number:	[REDACTED]	Application Received:	05/27/2014
Claims Administrator:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	NDC # 62991140305, NDC # 38779175603, NDC # 63370004035 & 38779038805		

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.

Case assigned 07/10/2014

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 \$135.00 in additional reimbursement for a total of \$385.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$385.00 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]

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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: N/A
- Red Book
- Other: OMFS Pharmacy Fee Schedule, LC 5307.1

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:** The Provider is dissatisfied with the reimbursement of \$0.00 for a compounded drug products billed as NDC: 62991140305, 38779175603, 63370004035 & 38779038805
- Per Labor Code Section 5307.1 (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 by 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.

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- The final review denied the billed pharmaceuticals and provided the following explanation: This item is packaged or bundled into another basic service or surgical procedure fee performed on this date of service, additional reimbursement disallowed.
- The final review denied the billed pharmaceuticals and provided the following explanation: This item is packaged or bundled into another basic service or surgical procedure fee performed on this date of service, additional reimbursement disallowed.
- 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 medications: Morphine, Fentanyl, Bupivacaine and Baclofen for date of service 11/26/2013.
- NDC 62991140305: supplied prescription indicated Morphine Sulfate HCL 30mg/ml total 22 ml.
- NDC 38779175603: supplied prescription indicated Fentanyl .9mg/ml total 22 ml.
- NDC 63370004035: supplied prescription indicated Bupivacaine 8mg/ml total 22 ml.
- NDC 38779038805: supplied prescription indicated Baclofen Powder 225mcg/ml total 22ml.
- Invoice documented paid cost \$115.00 for the compounded medication. OMFS Pharmacy Calculator allowance: \$127.78 + dispensing fee \$8.24 = 136.02. Documented paid cost + \$20.00 = \$135.00
- Reimbursement of 135.00 warranted based on the lesser of (paid costs vs. OMFS fee schedule)

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes NDC # 62991140305, 38779175603, 63370004035 & 38779038805

Date of Service 11/26/2013						
Compounded Drug Product						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
62991140305; 38779175603; 63370004035; 38779038805	\$ 11,180.00	\$ 0.00	\$ 5483.93	.66mg .0198 mg .176 mg .00495mg	\$135.00	DISPUTED SERVICE: Reimbursement of \$135.00 warranted.

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]