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 24, 2015

[redacted]

IBR Case Number:	CB15-0001991	Date of Injury:	03/30/2007
Claim Number:	[redacted]	Application Received:	10/27/2015
Claims Administrator:	[redacted]		
Date(s) of service:	07/10/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	NCD's 38779-0082-09, 63275-9913-09, 51552-1285-08		

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 $195.00 for the review cost and $1430.25 in additional reimbursement for a total of $1625.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $1625.25 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,

Paul Manchester, MD, MPH
Medical Director

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

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 denial of a compounded drug product containing NCD's 38779-0082-09, 63275-9913-09, 51552-1285-08 for date of service 07/10/2015.
- Provider is a compound pharmacy.
- 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 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.
- Claims Administrator provided the following explanation for denial: “In accordance with the guidelines in the MTUS CCR 9792.20-9792.26, Lidocaine is a non FDA approved agent, therefore is considered non reimbursable.”
- Authorization for requested procedure Flurbiprofen/Lidocaine Cream 20%/5% signed by Claims Administrator states “Approved”
- Documentation included a prescription for Flurbiprofen/Lidocaine 20%/5% cream 180gm.
- Claim form documented the following: Dispensed Qty. 180; Unit of Measure GM; Lidocaine HCL Powder NDC 38779-0082-09 Ingredient Qty. 9; Flurbiprofen Powder NDC 63275-9913-09, Qty. 36; Pentravan Plus Cream base NDC 51552-1285-08, Qty. 135.

- Reimbursement calculated on the Workers' compensation pharmacy fee schedule - Compound prescription Calculator
- Based on the NCD's 38779-0082-09, 63275-9913-09, 51552-1285-08 and billed quantity of 180 grams reimbursement of is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code: NCD's 38779-0082-09, 63275-9913-09, 51552-1285-08

Date of Service: 07/10/2015						
Compounded Drug						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
NCD's 38779-0082-09, 63275-9913-09, 51552-1285-08	$1,739.24	$0.00	$1,739.24	180 gm	$1,430.25	$1,430.25 Due to Provider

Copy to:

[redacted]

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