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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 25, 2015

[redacted]

IBR Case Number:	CB15-0000576	Date of Injury:	04/17/2014
Claim Number:	[redacted]	Application Received:	04/14/2015
Claims Administrator:	[redacted]		
Date Assigned:	5/14/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	99215-25, J7321-LT, and J7231-RT		

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 $116.38 in additional reimbursement for a total of $311.38.A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $311.38 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
- Negotiated contracted rates: PPO Discount 7%
- National Correct Coding Initiatives

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 denial of code 99215-25 and reimbursement of J7321-LT, and J7231-RT
- CMS 1500 form reflects J7321-LT and J7321-RT Supartz x 2.5 units.
- Claims Administrator reimbursed the Provider for 1 unit of each code billed.
- J7321 per Medi-cal payment system is as follows: "The usual dose is 2.5 ml of sodium hyaluronate (Supartz) into the affected knee at weekly intervals for up to five weeks for a total of five injections per affected knee. Some patients may experience benefit with three injections at weekly intervals."
- The units reflected on the CMS 1500 form reflects the unit of measure for the medication and not the unit cost. The unit cost is 1 (one) unit as reflected in the documentation.
- Based on the aforementioned documentation and guidelines, additional reimbursement is not warranted for J7321-Lt or J7321-RT
- Provider also billed code 99215-25 which Claims Administrator denied as "The submitted documentation does not identify significant, separately identifiable services greater than those usually required for the listed procedure. No additional allowance is recommended for mod. 15"
- Documentation abstracted from Provider's report does result in a separately identifiable Evaluation and Management level 99214. Provider has documented at least two of the

three components including a detailed history, examination and medical decision making of moderate complexity.

- Based on information reviewed, reimbursement for 99214 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99215-25 as 99214-25

Date of Service: 10/27/2014							
Physician Service							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
99215-25 as 99214	$217.29	$0.00	$217.29	1	N/A	$116.38	**DISPUTED SERVICE**: Allow reimbursement $116.38
J7321-LT	$280.75	$135.02	$145.73	1	N/A	$135.02	**DISPUTED SERVICE**: No reimbursement recommended
J7321-RT	$280.75	$135.02	$145.73	1	N/A	$135.02	**DISPUTED SERVICE**: No reimbursement recommended

Copy to:

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