

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 29, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000641	Date of Injury:	12/31/2013
Claim Number:	[Redacted]	Application Received:	4/24/2015
Claims Administrator:	[Redacted]		
Date Assigned:	5/21/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	20610, J7321, 76942 & WC002		

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 \$187.18 in additional reimbursement for a total of \$382.18. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$382.18 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]

[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 8%
- 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 codes 20610, J7321, 76942 & WC002
- Claims Administrator denied codes indicating on the Explanation of Review “Payment for this service has been denied because it appears to be unrelated to the claimed work illness or injury”
- Notification of Authorization from Claims Administrator dated November 21, 2014 was reviewed showing ‘Approved Service Description “Supartz Injections x5 Right Knee J7321. Approved Quantity 5-injection. Decision Date 11/21/2014. Date of Service 11/17/2014-02/17/2015”
- 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 cost. The unit cost is 1 (one) unit as reflected in the documentation. Provider’s PR-2 states “We then injected 2ml of Supartz into the right knee joint...”
- Based on the aforementioned documentation and guidelines, reimbursement is warranted for J7321 Supartz NDC 08363776101

- As pair codes exist between CPT 20610 and 76942, a modifier may be allowed if accompanied with supporting documentation. No modifier was appended to the column two code 76942 and therefore, reimbursement is not warranted for 76942.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 20610, J7321 and WC002 is recommended.

Date of Service: 1/16/2015							
Physician Service							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
20610	\$239.79	\$0.00	\$239.79	1	N/A	\$92.74	DISPUTED SERVICE: Allow reimbursement \$92.74
J7321	\$339.00	\$0.00	\$339.00	1	N/A	\$83.48	DISPUTED SERVICE: Allow reimbursement \$83.48
WC002	\$11.91	\$0.00	\$11.91	1	N/A	\$10.96	DISPUTED SERVICE: Allow reimbursement \$10.96

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 21.0	20610	76942	Allowed

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