

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 99214-25, WC002 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 99214-25 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. 25”
- 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 Claims Administrator denied WC002 reimbursement stating the report “does not meet the guidelines listed in CCR 9785.”
- DWC states, “The purpose of the 45-day rule in California Code of Regulations, Title 8, section 9785(f)(8) is to make sure that in the case of continuing treatment, that the patient’s progress is monitored no less than once every 45 days.” However, “Within a 45-day period, the primary treating physician can bill for as many PR-2’s as are medically necessary.”
- Based on information reviewed, reimbursement of WC002 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99214-25 and WC002

Date of Service: 12/5/2014							
Physician Service							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
99214	\$162.68	\$0.00	\$162.68	1	N/A	\$116.38	DISPUTED SERVICE: Allow reimbursement \$116.38
WC002	\$15.48	\$0.00	\$15.48	1	N/A	\$11.08	DISPUTED SERVICE: Allow reimbursement \$11.08
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

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