



Pended Claim Review: HCL-2026-0214339

Field	Detail
Member	Ryan Oakley, Brightwater PPO 1500 (BWH-PPO-1500)
Service	MRI knee without contrast (CPT 73721) · Primary osteoarthritis, right knee (ICD-10 M17.11)
Provider	Dr. Nicholas Gatling (In network, Family medicine)
Service date / received	2026-10-10 / 2026-10-18
Codes	CPT 73721 · ICD-10 M17.11
Billed	\$1,323.94
Pended on	Prior authorization check
Other coverage	None (member's other_coverage field is blank)

Decision: Send to clinical review for medical necessity. The reviewer makes the decision.

1. Review steps, in order

Step	Result	Data and source
1. Eligibility	Pass	Coverage 2024-01-12 to open, status Active, covers DOS 2026-10-10 (health.members; extra/health-claims-guidelines.md:8)
2. Coordination of benefits	Pass	other_coverage blank — no primary payer to chase (health.members; extra/health-coordination-of-benefits.md:4-6)
3. Timely filing	Pass	Received 2026-10-18, 8 days after DOS 2026-10-10, within the 90-day in-network limit for BWH-PPO-1500 (health.plans timely_filing_in_days=90; extra/health-claims-guidelines.md:17-18)
4. Network and referral	Pass	Dr. Gatling is in network; PPO 1500 needs no referral (referral_required=0) and covers out-of-network care anyway (extra/health-plan-benefits.md:14; extra/health-claims-guidelines.md:21-22)
5. Prior authorization	Pass, via 5.2	PA-00214339: approved MRI knee with contrast (73722), same member and provider, valid 2026-09-30 to 2026-11-29, covering the DOS. Claim bills the lesser study, MRI knee without contrast (73721). An authorization for a more extensive version covers a lesser one (extra/health-claims-guidelines.md:35-36) — same fact pattern as HD-25-08 (extra/health-past-decisions.md:6)
6. Coding	Pass	Single line, no modifiers, 1 unit; no other 2026 claims for this member on file — no bundling, duplicate or unit issue (health.claim_lines; extra/health-coding-edits.md)
7. Benefit limits	Pass / not applicable	Not a visit-limited service (not therapy)

8. Medical necessity	Fails on the facts shown	Diagnosis is M17.11, primary osteoarthritis of the right knee. Medical policy MP-IMG-03.B lists this exact fact pattern as not medically necessary: "knee osteoarthritis (M17.11) already diagnosed by X-ray, to stage it" (extra/health-medical-policy-imaging.md:17-22). Nothing on the claim shows a suspected tear with mechanical symptoms, or persistent pain after 6 weeks of conservative care with non-diagnostic X-rays — the two conditions that would make it necessary
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Step 8 (medical necessity) decides the claim; steps 1-7 all passed and need no re-check when the claim resumes, unless clinical review raises new facts.

2. What the pend reasons turned out to mean

- **Prior authorization check:** Fine, not a real problem. The automated check could not match the exact CPT billed (73721) to the authorization on file (73722, the contrast version), so it pended. Rule 5.2 resolves this: the broader authorization for the more extensive study covers the lesser one performed (extra/health-claims-guidelines.md:35-36). The actual issue the automated check never looks at is medical necessity (step 8), which the diagnosis fails on its face (extra/health-medical-policy-imaging.md:17-22).

3. Decision

- **Line 1 (CPT 73721, MRI knee without contrast, \$1,323.94 billed):** Clinical review for medical necessity. Claims staff do not deny for medical necessity themselves (extra/health-claims-guidelines.md:46-48). If the clinical reviewer upholds the policy criteria against the claim's facts, the resulting denial would use reason code 50, "Not medically necessary (clinical review only)" (extra/health-denial-codes-and-letters.md:11). Do not deny code 197: the prior-authorization step passed under rule 5.2, so that pend reason is resolved, not a denial basis.
- **Sign-off:** Not required. A senior reviewer approves only claims over \$10,000 billed; this claim is billed at \$1,323.94 (extra/health-claims-guidelines.md:54).
- **For the file:** When the claim resumes after clinical review, re-check only the clinical reviewer's finding; steps 1-7 above are already settled and do not need re-checking.

4. Deadlines and precedent

Deadline	Date
Decide the pended claim, or ask for what is missing — 15 business days from the pend (extra/health-timelines-and-appeals.md:9)	2026-11-06
Clinical reviewer's time to answer, if the claim is routed for information instead	n/a — this claim is routed to clinical review, not a request for information

Past decision followed: HD-25-12 — authorized lumbar MRI that did not meet MP-IMG-03's clinical criteria on the claim's facts was sent to clinical review, and the reviewer denied it with code 50 (extra/health-past-decisions.md:7). This claim follows the same path for the same reason (policy criteria not met on the facts shown), applied to MP-IMG-03.B (knee) instead of A (spine). HD-25-08 is also on point for the prior-authorization step: a knee MRI without contrast performed under an authorization for the contrast version was paid under that authorization (extra/health-past-decisions.md:6) — confirming that step 5 here

is not a problem.

The question asked

Help me work pended health claim HCL-2026-0214339: MRI knee without contrast · Primary osteoarthritis, right knee for Ryan Oakley (Brightwater PPO 1500), from Dr. Nicholas Gatling (In network), service date 2026-10-10. It pended on: Prior authorization check. I took it from the queue; I make the decision. Use datalake_query on the health data:

1. *SELECT * FROM health.claims WHERE claim_id = 'HCL-2026-0214339' and SELECT * FROM health.claim_lines WHERE claim_id = 'HCL-2026-0214339' ORDER BY line_no*
2. *SELECT * FROM health.members WHERE member_id = 'BWH700163122' and SELECT * FROM health.plans WHERE plan_id = 'BWH-PPO-1500'*
3. *SELECT * FROM health.providers WHERE npi = '1003013195'*
4. *SELECT * FROM health.prior_auths WHERE member_id = 'BWH700163122' ORDER BY valid_from DESC*
5. *SELECT claim_id, service_date, provider_npi, procedure_codes, status, paid_amount FROM health.claims WHERE member_id = 'BWH700163122' AND claim_id != 'HCL-2026-0214339' AND service_date >= toStartOfYear(toDate('2026-10-10')) ORDER BY service_date* Read in the workspace: *extra/health-claims-guidelines.md, extra/health-plan-benefits.md, extra/health-coding-edits.md, extra/health-coordination-of-benefits.md, extra/health-medical-policy-imaging.md, extra/health-timelines-and-appeals.md, extra/health-denial-codes-and-letters.md and extra/health-past-decisions.md. Work through the review steps in extra/health-claims-guidelines.md in order (eligibility, coordination of benefits, timely filing, network and referral, prior authorization, coding, benefit limits, medical necessity) and answer, short and easy to scan, citing each document as path:line:*
6. *Each step: passes, or the problem, with the data that shows it.*
7. *What the pend reason turned out to mean (the check may have stopped on something that is fine).*
8. *Decision: pay, adjust the allowed amount, deny (with the reason code), request information, send to clinical review or refer to SIU; line by line where the lines differ.*
9. *The deadline, and any past decision it follows. Then offer to draft the member's notice or the provider's request from the templates. If I ask for a written report or a PDF, follow extra/templates/pended-claim-review-template.md.*