

**MAXIMUS FEDERAL SERVICES, INC.**

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



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

October 15, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0001691	Date of Injury:	01/28/2015
Claim Number:	[Redacted]	Application Received:	09/22/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	02/12/2015 – 02/12/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	15851		

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 \$54.59 in additional reimbursement for a total of \$249.59. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$249.59** 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, M.D., M.P.H.  
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
- OMFS

## **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 seeking remuneration for 15851 services performed on 02/12/2015.**
- The Claims Administrator denied services based on “documentation.”
- **CPT 15851 Code Description:** Removal of sutures **under anesthesia (other than local).**
- Report entitled, “Consulting-Primary Treating Physician Progress Report” reviewed for the following:
  - Site of Suture Removal – Site not directly indicated
  - Anesthesia Report or Method – Nod Documented
  - Description of Procedure – Not Documented
  - Outcome of Procedure – Not Documented
- Treatment Plan indicates “D/C (? illegible) Sutures” however, the actual procedure is not documented in the body of the report.
- Elements of Report reflect the following Evaluation and Management Service:
  - Problem Focused History
  - Problem Focused Exam
  - Low Complexity Medical Decision Making
  - 2 of 3 Meet or Exceed = 99212
- Submitted Documentation for Date of Service 02/12/2015 does not reflect the RVU work component of the submitted **Surgical CPT**. As such, verification of 15851 service cannot be determined and the Claims Administrator’s decision for **15851 service is upheld;** Reimbursement for documented service: **99212 is recommended.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 15851**

<b>Date of Service:</b> 02/12/2015 Physician Services						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
15851	\$130.00	\$0.00	\$130.00	1	\$54.59	<b>99212 Service Recommended</b>

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