

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on March 26, 2004.

The IRO reviewed CPT Codes 95851, 97012, 97110, 97530, 99070, 99071, 97250, 97010, 97750-FC, 99213, 85025, 80019, and 36415 that were denied based upon "U".

The Division has reviewed the enclosed IRO decision and determined that **the Requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

The IRO reviewer concluded that CPT Codes 99213, 85025, 80019, 36415 and 97750-FC from 05/21/03 through 09/25/03 **were** found to be medically necessary. CPT Codes 95851, 97110, 97530, 99070, 99071, 97250, 97010, and 97012 from 05/21/03 through 09/25/03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for CPT Codes 95851, 97012, 97110, 97530, 99070, 99071, 97250, 97010, 97750-FC, 99213, 85025, 80019, and 36415.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

On August 6, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 99213 for date of service 06/20/03. Neither party submitted EOBs; therefore, these dates of service will be reviewed according to the 1996 Medical Fee Guideline. Per the 1996 Medical Fee Guideline, E & M Ground Rule (VI)(B) reimbursement in the amount of \$48.00 is recommended.
- CPT code 99080-73 for date of service 09/25/03 denied as "U". Per Rule 129.5 the Work Status Report is a required report; therefore, MDR has jurisdiction over this matter. Per Rule 133.106(f)(1) reimbursement in the amount of \$15.00 is recommended.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby **ORDERS** the respondent to pay the unpaid medical fees outlined above as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);

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- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 05/21/03 through 09/25/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this _____4th___ day of ___November __, 2004

Medical Dispute Resolution Officer
Medical Review Division

MF/mf

Enclosure: IRO decision

MAXIMUS

August 9, 2004

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter**

RE: MDR Tracking #: M5-04-2630-01

TWCC #:

Injured Employee:

Requestor: Southwest Med Center

Respondent: Texas A&M System

MAXIMUS Case #: TW04-0248

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by

the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the MAXIMUS external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 56 year-old female who sustained a work related injury on 3/___/02. The patient reported that while at work she tripped over some books that were left on the floor. A MRI of the cervical spine performed on 8/19/02 was reported to have shown degenerative changes along with spondylosis, a 3mm focal protrusion at the 4th intervertebral disc, a 5mm focal protrusion at the 5th disc, and a 5-6mm focal protrusion at the 6th intervertebral disc. An electrophysiological study performed on 7/10/02 was reported to have revealed a left C8 radiculopathy. An EMG performed on 11/26/02 indicated evidence of mild ulnar neuropathy at or near the left elbow. The patient was initially treated from 3/02 through 4/03 with therapeutic electrical stimulation, ultrasound, hot/cold packs and manipulation. The patient changed treating doctors on 5/7/03 and began treatment that included chiropractic care and physical therapy treatments.

Requested Services

ROM measure, mech tract, ther exer, ther act, sup and materials, ed supplies, myofascial release, hot/cold pack ther, FCA, office visit, blood count, more clinic chem. tests, manual therapy techniques, manual muscle testing and venipuncture from 5/21/03 through 9/25/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Physical Therapy SOAP noted 5/1/03 – 12/5/03
2. FCE 10/24/03
3. Letter from Wol =Med 9/11/03

Documents Submitted by Respondent:

1. Electrophysiological Study Report 7/10/02
2. MRI report 8/19/02
3. EMG report 11/26/02

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a 56 year-old female who sustained a work related injury to her neck, shoulder, and back on 3/7/02. The MAXIMUS physician reviewer indicated that the patient received extensive physical therapy consisting of modalities/traction/exercises/and myofascial release activities from 3/8/02 through 4/9/03. The MAXIMUS physician reviewer noted that the patient's pain level remained or changed to a 10 by 4/9/03. The MAXIMUS physician reviewer explained that an FCE performed on 12/30/02 indicated the patient could perform light sedentary physical work. The MAXIMUS physician reviewer indicated that the patient had no significant benefit from the extensive treatment she had received. The MAXIMUS physician reviewer explained that the patient continued with very similar physical therapy from 5/21/03. The MAXIMUS physician reviewer indicated that a review of the documentation provided demonstrated that the patient had no improvement in pain level. The MAXIMUS physician reviewer explained that the documentation provided indicated that the patient had been treated with therapeutic exercises and therapeutic activities.

Therefore, the MAXIMUS physician consultant concluded that the office visit, blood count, more clinic chem. tests, venipuncture, and FCE from 5/21/03 through 9/25/03 were medically necessary to treat this patient's condition. However, the MAXIMUS physician consultant further concluded that the range of motion measure, the exer, the act, supplies and materials, ed supplies, myofascial release, hot/cold therapy, manual therapy techniques, manual muscle testing and mechanical traction were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department