

MDR Tracking Number: M5-05-1858-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 3-7-05.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The IRO reviewed office visits from 3-12-04 through 8-10-04 that were denied by the insurance carrier for medical necessity.

The office visits from 3-12-04 through 8-10-04 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. The amount due the requestor for the medical necessity issues is \$251.62.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 4-5-05 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 99080-73 on 3-12-04 and 8-6-04 was denied by the carrier as "V - unnecessary medical treatment", however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. A referral will be made to Compliance and Practices for this violation of the rules. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requestor submitted relevant information to support delivery of service. **Recommend reimbursement of \$30.00.**

Regarding CPT code 99212 on 4-2-04, 6-17-04 and 6-28-04: Neither the carrier nor the requestor provided EOB's. There is no "convincing evidence of the carrier's receipt of the request for reconsideration" according to 133.307 (g)(3)(A). **Recommend no reimbursement.**

Regarding CPT code 99080-73 on 4-2-04 and 6-03-04: Neither the carrier nor the requestor provided EOB's. There is no "convincing evidence of the carrier's receipt of the request for reconsideration" according to 133.307 (g)(3)(A). **Recommend no reimbursement.**

**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 totaling \$281.62 from 3-12-04 through 8-10-04 outlined above as follows: In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.**

This Decision and Order is hereby issued this 31<sup>st</sup> day of May, 2005.

Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO decision

May 26, 2005

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

### **NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-05-1858-01**  
**TWCC #: \_\_\_\_\_**  
**Injured Employee: \_\_\_\_\_**  
**Requestor: Southeast Health Services**  
**Respondent: Dallas ISD**  
**MAXIMUS Case #: TW05-0071**

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 chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor 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 chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

#### **Clinical History**

This case concerns a female who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work as a teacher, she fell down a flight of 14 steps injuring her head, neck, lower back, right knee, right hand, and left elbow. The patient was evaluated in an emergency room where she underwent a CT scan of her head, X-rays of her left elbow, right knee, and lumbar spine. The patient was diagnosed with head injury with scalp laceration, third right middle finger abrasion, left elbow sprain, right knee sprain, and cervical and lumbar strain/sprain. The patient began a course of physical therapy. On 6/10/03 the patient underwent an MRI of the cervical spine that showed bulging discs at C4-5, C5-6, and C6-7, and an MRI of the right hand and left elbow that was reported as normal. On 4/4/04 the patient underwent a CT cervical myelogram that showed a chronic nondisplacement type 2 fracture over the entire process and the bulging

discs at C4-5, C5-6, and C6-7. An EMG of the left upper extremity performed on 4/6/04 revealed possible radiculopathy, exclude neuropathy. On 9/3/04 the patient underwent second degree fusion with decompression of C3-C7 and 10/15/04 the patient underwent a fusion from C4-C7.

### **Requested Services**

99212 Office visit and 99211 office visit from 3/12/04 through 8/10/04.

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

#### *Documents Submitted by Requestor:*

1. Letter of Medical Necessity 1/14/05
2. Review of Medical History and Physical Exam 1/24/05
3. Exercise Records (no dates)
4. Designated Doctor Evaluation 7/28/04
5. Office Notes 4/4/03 – 4/12/05
6. Operative Note 8/25/04
7. Treatment Records 12/15/03 – 6/28/04

#### *Documents Submitted by Respondent:*

1. No documents submitted

### **Decision**

The Carrier's denial of authorization for the requested services is overturned.

### **Rationale/Basis for Decision**

The MAXIMUS chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her head, neck, lower back, right knee, right hand, and left elbow on \_\_\_\_\_. The MAXIMUS chiropractor reviewer indicated that according to the medical records provided, the injured worker was evaluated in the office between 3/12/04 and 8/10/04, the dates in dispute. The MAXIMUS chiropractor reviewer also explained that according to the CPT manual regarding extended medical services, office visits coded 99219 and 99211 must have 2 out of 3 of the following components: history, examination, and medical decision making. The MAXIMUS chiropractor reviewer noted that in addition to these three components, they must exceed the published descriptions of problem focused, expanded problem focused, detailed, and comprehensive office visits. The MAXIMUS chiropractor reviewer explained that the office visits in dispute did include 2 out of the 3 key components for E/M services in each visit as well as having the components for problem focused description levels.

Therefore, the MAXIMUS chiropractor consultant concluded that the 99212 office visit and 99211 office visit from 3/12/04 through 8/10/04 were medically necessary to treat this patient's condition.

Sincerely,  
**MAXIMUS**

Elizabeth McDonald  
State Appeals Department