

MDR Tracking Number: M5-04-0663-01

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, 133.307 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. This dispute was received on 10-31-03.

The IRO reviewed office visits, hot/cold pack therapy, electrical stimulation (unattended), ultrasound therapy and neuromuscular stimulator rendered from 11-13-02 through 12-31-02 that were denied based "U".

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 \$650.00** 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.

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. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-16-04, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
11-13-02 through 12-12-02 (7 DOS)	97010	\$105.00 (1 unit @ \$15.00 X 7 DOS)	\$0.00	F	\$11.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service for all DOS. Reimbursement recommended in the amount of \$11.00 X 7 DOS = \$77.00
11-18-02 through 12-23-02 (5 DOS)	97010	\$75.00 (1 unit @ \$15.00 X 5 DOS)	\$0.00	N	\$11.00	96 MFG MEDICINE GR(I)(9)(a)(ii)	Requestor submitted relevant information to meet documentation criteria for all DOS. Reimbursement recommended in the amount of \$11.00 X 5 DOS = \$55.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
11-13-02 through 12-12-02 (7 DOS)	97014	\$126.00 (1 unit @ \$18.00 X 7 DOS)	\$0.00	F	\$15.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service for all DOS. Reimbursement recommended in the amount of \$15.00 X 7 DOS = \$105.00
11-18-02 through 12-23-02 (5 DOS)	97014	\$90.00 (1 unit @ \$18.00 X 5 DOS)	\$0.00	N	\$15.00	96 MFG MEDICINE GR(I)(9)(a)(ii)	Requestor submitted relevant information to meet documentation criteria for all DOS. Reimbursement recommended in the amount of \$15.00 X 5 DOS = \$75.00
11-13-02 through 12-12-02 (7 DOS)	97035	\$182.00 (1 unit @ \$26.00 X 7 DOS)	\$0.00	F	\$22.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service for all DOS. Reimbursement recommended in the amount of \$22.00 X 7 DOS = \$154.00
11-18-02 through 12-23-02 (4 DOS)	97035	\$104.00 (1 unit @ \$26.00 X 4 DOS)	\$0.00	N	\$22.00	96 MFG MEDICINE GR(I)(9)(a)(iii)	Requestor submitted relevant information to meet documentation criteria for all DOS. Reimbursement recommended in the amount of \$22.00 X 4 DOS = \$88.00
11-15-02	E0230	\$40.00 (1 unit)	\$0.00	M	DOP	96 DME GR (VIII)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.
11-18-02 and 11-22-02 (2 DOS)	99213	\$120.00 (1 unit @ \$60.00 X 2 DOS)	\$0.00	N	\$48.00	96 E/M GR(VI)(B)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$48.00 X 2 DOS = \$96.00
12-30-02	99080-73	\$20.00 (1 unit)	\$0.00	F	\$15.00	Rule 133.106(f)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$15.00
<b>TOTAL</b>		\$862.00	\$0.00				Requestor is entitled to reimbursement in the amount of \$665.00

### ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 11-13-02 through 12-31-02 in this dispute.

This Findings and Decision and Order are hereby issued this 10<sup>th</sup> day of June 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh  
Enclosure: IRO Decision

January 21, 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 #: M5-04-0663-01**  
**TWCC #: \_\_\_\_**  
**Injured Employee: \_\_\_\_**  
**Requestor: Neuromuscular Institute of Texas-P.A.**  
**Respondent: City of San Antonio**  
**MAXIMUS Case #: TW03-0652**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). 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. 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 42 year-old male who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work he was pulling a heavy metal object when he began to experience sharp pain in his left arm. The patient was evaluated in an emergency room where he was given a sling, brace and medications. An MRI of the left elbow dated 11/21/02 showed localized fluid near the lateral epicondyle consistent with epicondylitis. The diagnosis for this patient is left elbow epicondylitis. Treatment for this patient's condition has included ultrasound, interferential stimulation and hot/cold packs. The patient also was treated with an injection to the left elbow of Marcaine on 11/18/02.

## **Requested Services**

Office visits, hot/cold pack therapy, electrical stimulation (unattended), ultrasound therapy and neuromuscular stimulator from 11/13/02 through 12/31/02.

## **Decision**

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

## **Rationale/Basis for Decision**

The MAXIMUS physician reviewer noted that this case concerns a 42 year-old male who sustained a work related injury to his left elbow on \_\_\_\_\_. The MAXIMUS physician reviewer indicated that this elbow injury has resulted in left lateral epicondylitis with pain, decreased range of motion and decreased strength in the left forearm and hand. The MAXIMUS physician reviewer noted that between 11/13/02 and 12/31/02 the patient was treated with physical therapy for decreased flexibility and decreased grip in the left wrist and swelling and tenderness in the left epicondyle. The MAXIMUS physician reviewer indicated that the patient underwent local anesthetic injection on 11/18/02 and that the patient was reported to have decreased pain. However, the MAXIMUS physician reviewer explained that the patient continued with decreased grip strength, decreased elbow extension and decreased supination/pronation of left forearm. The MAXIMUS physician reviewer noted that the patient continued with physical therapy that included electrical stimulation, ultrasound and heat/cold. The MAXIMUS physician reviewer indicated that a progress note dated 12/23/02 indicated that the patient continued with decreased grip strength and that another progress note dated 12/30/02 indicated that the patient reported decreased pain but continued difficulty with grip and lifting with his left upper extremity. The MAXIMUS physician reviewer explained that the patient made some improvement with physical therapy indicated by some increased range in motion and some decreased pain. Therefore, the MAXIMUS physician consultant concluded that the office visits, hot/cold pack therapy, electrical stimulation (unattended), ultrasound therapy and neuromuscular stimulator from 11/13/02 through 12/31/02 were medically necessary to treat this patient's condition.

Sincerely,  
MAXIMUS

Elizabeth McDonald  
State Appeals Department