

MDR Tracking Number: M5-04-1460-01

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 01-23-04.

The IRO reviewed therapeutic exercises, neuromuscular reeducation, aquatic therapy, physical performance testing, electrical stimulation therapy and whirlpool rendered from 04-04-03 through 05-23-03 that were denied based upon "V" and "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 06-24-04, 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.

CPT code 97112 (8 units) dates of service 03-24-03 through 03-31-03 (4 DOS) denied with denial code "O" (reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time. Bill has been paid according to state fee guidelines and/or state rules and regulations). No payment has been made by the carrier. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$280.00 (\$35.00 X 8 units).

CPT code 97113 (8 units) dates of service 03-24-03 through 03-31-03 (4 DOS) denied with denial code "O" (reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time. Bill has been paid according to state fee guidelines and/or state rules and regulations). No payment has been made by the carrier. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$416.00 (\$52.00 X 8 units).

CPT code 97110 dates of service 03-26-03, 03-28-03 and 03-31-03 denied with denial code "O" (reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time. Bill has been paid according to state fee guidelines and/or state rules and regulations. Date of service 04-02-03 revealed that neither the requestor nor the respondent submitted an EOB. Date of service 05-28-03 denied with denial code "F" (submitted documentation does not support or meet the criteria for one-on-one therapy that is identified in the

fee Guideline Rules and or CPT code descriptor for reimbursement). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

CPT code 97110 date of service 04-04-03 is listed on the table of disputed services, but no HCFA was submitted by the requestor. This service will not be reviewed by the Medical Review Division.

Review of CPT code 97112 date of service 05-28-03 revealed that neither the requestor nor the respondent submitted an EOB. The requestor did not submit convincing evidence of carrier receipt of the providers request for an EOB per Rule 133.307(e)(2)(B). No reimbursement recommended.

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 03-24-03 through 03-31-03 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 Findings and Decision and Order are hereby issued this 30th day of November 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

October 29, 2004

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

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter B**

RE: MDR Tracking #: M5-04-1460-01

TWCC #: ____

Injured Employee: ____

Requestor: Dr. Alan Henson

Respondent: Twin City Fire Ins. Co.

MAXIMUS Case #: TW04-0087

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 29 year-old female who sustained a work related injury on _____. The patient reported that while at work she was cleaning a tub with oil in it when she slipped, landed and injured her back. The patient was evaluated in the emergency room and released. The patient began treatment with a chiropractor who began her on a course of therapy that consisted of massage therapy, chiropractic adjustments, whirlpool, electrical stimulation, ice packs, exercises and ultrasound. On 3/14/03 the patient underwent an NCV test that indicated a proximal lesion particularly on left indicating a possible plexopathy or radiulopathy. An MRI of the lumbar spine on 3/27/03 showed evidence of disc desiccation without significant loss of disc space height, and approximately a 3mm central, soft tissue disc bulge/protrusion was demonstrated to touch and effaced the thecal sac below the level of the exit of the nerve roots.

Requested Services

Therapeutic exercises, neuro reeducation, aquatic therapy, physical performance test, electrical stimulation therapy, and whirlpool from 4/4/03 through 5/23/03.

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a 29 year-old female who sustained a work related injury to her back on _____. The MAXIMUS physician reviewer indicated that the patient had been treated with chiropractic treatment, neuromuscular rehabilitation, aquatic therapy and exercises. The MAXIMUS physician reviewer noted that the patient was evaluated on 3/11/03 and was found to have minimal decrease in spinal flexion but otherwise no objective findings. The MAXIMUS physician reviewer explained that the office notes from 4/7/03 through 5/23/03 indicated that the patient's pain level remained at an average of 2/10. The MAXIMUS physician reviewer indicated that the documentation provided did not contain objective measurements indicating improvement in this patient's condition. The MAXIMUS physician reviewer noted that there were two computerized spinal range of motion exams (3/3/03 and 4/14/03) included in the file that showed minimal improvement in this patient's condition overall and a 0% spine range of motion impairment. The MAXIMUS physician reviewer explained that even if the patient had a minimal deficit in her lumbar spine range of motion, the patient could have continued home exercises without skilled supervision being necessary. The MAXIMUS physician reviewer also explained that although the patient had findings on MRI exam, this did not affect her course of treatment as she continued to receive the same treatment. The MAXIMUS physician reviewer further explained that the patient did not show any change in pain level with treatment rendered. Therefore, the MAXIMUS physician consultant concluded that the therapeutic exercises, neuro reeducation, aquatic therapy, physical performance test, electrical stimulation therapy and whirlpool from 4/4/03 through 5/23/03 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department