

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

|   |  |
|---|--|
| <b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC   | <b>Response Timely Filed?</b> ( ) Yes (X) No |
| Requestor's Name and Address<br><b>Michael McGarrah DC</b><br><b>C/o Casaubon Group</b><br><b>PO Box 296111</b><br><b>Lewisville TX 75029</b> | MDR Tracking No.: M5-04-1853-01              |
|   | TWCC No.:                                    |
|   | Injured Employee's Name:                     |
| Respondent's Name and Address Rep Box #42<br><br><b>American Protection Insurance c/o Harris &amp; Harris</b>                                 | Date of Injury:                              |
|   | Employer's Name:                             |
|   | Insurance Carrier's No.:                     |

### PART II: SUMMARY OF DISPUTE AND FINDINGS

| Dates of Service |         | CPT Code(s) or Description           | Did Requestor Prevail?  |
|------------------|---------|--------------------------------------|---|
| From             | To      |                                      |   |
| 2-28-03          | 4-29-03 | 97530, 97110, 97112, 99213, 97750-MT | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 8-13-03          | 9-3-03  | 97012                                | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 9-15-03          | 11-3-03 | 99213                                | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

### PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

Date of service 2-19-03 is untimely and ineligible for review per TWCC Rule 133.308 (e)(1).

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the majority of the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues is \$3,351.00.

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 5-24-05 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.

Code 97010, 97012, 97014 billed on date of service 2-24-03 was denied as 'F - fee guideline MAR reduction'; however, no payment was made. Recommend reimbursement of \$11.00 + \$20.00 + \$15.00 = \$46.00. The carrier will be billed for an inappropriate denial.

Code 99080-73 billed on date of service 4-4-03 was denied as 'N, not appropriately documented'. The requestor did not submit a copy of the TWCC-73; therefore, documentation requirements cannot be addressed. No reimbursement recommended.

Code 99080-73 billed on date of service 11-3-03 was denied as 'F,111-002, non-contracted provider'. Recommend reimbursement of \$15.00.

Code 99213 billed on date of service 9-3-03 was denied as 'F-111-002, non-contracted provider'. Recommend reimbursement of \$59.00 ( $47.20 \times 125\% = \$59.00$ ).

Code 97010 billed for date of service 9-30-03 was denied as 'F,111-02, non-contracted provider and 885-001, fee guideline MAR reduction, payment recommended of \$11.00'. The EOB shows payment recommended, however, requestor states no payment received per the table of disputed services. Per the 2002 Medical Fee Guideline, this code is a bundled code and considered an integral part of a therapeutic procedure(s). Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment will not be made. Payment is included in the allowance for another therapy service/procedure performed. Therefore, no reimbursement recommended.

Code G0283 billed for date of service 9-30-03 was denied as 'F,111-02, non-contracted provider and 663, reimbursement has been calculated per the State fee guideline – payment recommended of \$15.81.' The EOB shows payment recommended, however, requestor states no payment received per the table of disputed services. Recommend reimbursement of \$14.91 ( $\$11.93 \times 125\% = \$14.91$ ).

The amount due from the carrier for the medical fee issues is \$134.91.

**PART IV: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount AND  $\$3,351.00 + \$134.91 = \$3,485.91$  for the services in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20 days of receipt of this Order.

Findings & Decision by:

s

8-1-05

Authorized Signature

Typed Name

Date

Ordered by:

8-1-05

Medical Necessity Team

Authorized Signature

Typed Name

Date

**PART V: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_

**PART VI: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and the TWCC Chief Clerk of Proceedings/Appeals Clerk must receive it within 20 days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

May 7, 2004

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

**NOTICE OF INDEPENDENT REVIEW DECISION**  
**Amended Determination 3/28/05**

**RE: MDR Tracking #: M5-04-1853-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Dr. Michael McGarrah**  
**Respondent: American Protection Ins. c/o Harris & Harris**  
**MAXIMUS Case #: TW04-0143**

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. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement and is familiar with the condition and treatment options at issue in this appeal. 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 she fell over a box causing injury to her back, left side and head. A MRI of the lumbar spine performed on showed anterior annular spondylosis at T11-12, L1-2, L2-3, L3-4, and L4-5, at L3-4 disc desiccation 1mm annular bulge, at L4-5 disc desiccation 2mm annular bulge, lig. flavum hypertrophy and facet hypertrophy, mild central canal and right foraminal stenosis, and L5-S1 2mm disc protrusion mild facet hypertrophy. An EMG/NCV performed on 3/25/03 was reported to indicate lower extremity radiculopathy. A follow up EMG/NCV on 6/15/03 was reported to indicate that the radiculopathy reported earlier had resolved. Treatment for this patient's condition has included chiropractic manipulations, medications, and a course of physical therapy.

## Requested Services

Therapeutic activities, therapeutic exercises, neuromuscular reeducation, office visits, and physical performance testing from 2/28/03 through 4/29/03, mechanical traction 8/13/03 and 9/3/03, office visits 9/15/03, 9/30/03 and 11/3/03.

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

#### *Documents Submitted by Requestor:*

1. SOAP notes 1/8/03 – 3/23/04
2. Therapy notes 2/14/03 – 4/18/03
3. Electrodiagnostic testing 3/25/03
4. MRI lumbar spine report 4/30/03

#### *Documents Submitted by Respondent:*

1. No documents submitted

## 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 chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her back, left side and head on .. The MAXIMUS chiropractor reviewer also noted that this patient was know to have prior leg pains prior to the work related injury according to a SOAP note dated 4/1/03. The MAXIMUS chiropractor reviewer indicated that the patient suffered an injury that aggravated pre-existing degenerative changes. The MAXIMUS chiropractor reviewer noted that the treatment period in question is from 2/28/03 through 9/3/03. However, the MAXIMUS chiropractor reviewer explained that an MRI of the lumbar spine that indicated a degenerative spine was not performed until 4/30/03, making the findings unavailable until 5/03. The MAXIMUS chiropractor reviewer explained that the patient did show objective improvement in her leg pain by 6/03. The MAXIMUS chiropractor reviewer also explained that the patient reached maximum medical improvement in 6/03. The MAXIMUS chiropractor reviewer further explained that care beyond mid 6/03 was symptomatic and not medically necessary.

Therefore, the MAXIMUS chiropractor consultant concluded that the therapeutic activities, therapeutic exercises, neuromuscular reeducation, office visits, and physical performance testing from 2/28/03 through 4/29/03 were medically necessary. However, the MAXIMUS chiropractor consultant concluded that the mechanical traction 8/13/03 and 9/3/03, office visits 9/15/03, 9/30/03 and 11/3/03 were not medically necessary to treat this patient's condition.

Sincerely,

Elizabeth McDonald  
State Appeals Department

MAXIMUS