

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 04/03/04.

The IRO reviewed CPT Codes 99090, 99354, 98943, 97140, 97110, 97139-EU, 64999, 97035, 97028, 99215, 99214, S9982 that was denied based upon "U" and "V".

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.

The IRO reviewer **overturned** the Carrier's determination and concluded that these services were medical necessary for the treatment of the injured workers condition.

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 January 19, 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 99205 for date of service 05/12/03 denied for "N". Per Rule 133.307(g)(3)(B) and the 1996 Medical Fee Guideline, E&M Ground Rule (VI)(A) SOAP notes support the services were rendered as billed. Reimbursement in the amount of \$137.00 is recommended.
- CPT Code 99354 for date of service 06/13/03 denied for "N". Per Rule 133.307(g)(3)(B) and the 1996 Medical Fee Guideline, CPT Descriptor the submitted SOAP note does not support the level of service billed. Reimbursement is not recommended.
- CPT Code 64999-22 for dates of service 08/20/03, 08/27/03, 08/29/03, 09/02/03, 09/05/03, and 09/22/03 denied as "N". Per Rule 133.307(g)(3)(B) the SOAP notes support the services were rendered as billed. Per Rule 134.202(c)(6) the Carrier will establish a payment amount. Reimbursement is recommended.

- CPT Code 97035 for dates of service 08/29/03 and 09/15/03 denied as “N”. Per Rule 133.307(g)(3)(B) the SOAP notes support the services were rendered as billed. Per Rule 134.202(b) reimbursement in the amount of \$29.86 (\$14.93 x 2) is recommended.
- CPT Code 99080-73 for dates of service 09/03/03, 09/04/03, 11/25/03, 12/001/03, 12/15/03, 12/29/03, 01/12/04, and 02/02/04 denied as “V”. Per Rule 129.5 the TWCC-73 is a Commission required report, which MDR has jurisdiction over. Per Rule 133.106(f)(1) reimbursement in the amount of \$120.00 (\$15.00 x 8) is recommended.
- CPT Code 99080-73 for date of service 09/22/03 denied as “N”. Per Rule 129.5 the TWCC-73 is a Commission required report, which MDR has jurisdiction over. Per Rule 133.307(g)(3)(B) requestor has submitted the Work Status Report to support services were rendered as billed. Per Rule 133.106(f)(1) reimbursement in the amount of \$15.00 is recommended.
- CPT Code 99080-73 for date of service 11/03/03 denied as “F”. The submitted EOB shows payment was made for this CPT code on this date of service. Reimbursement is not recommended.
- CPT Code 97014 for date of service 09/04/03, neither party submitted an EOB. Per Rule 133.204(c)(6) reimbursement is recommended and the Carrier shall assign a payment amount. Reimbursement recommended; the carrier shall assign a payment amount.
- CPT Code 98943 for date of service 09/15/03 denied as “N”. Per Rule 133.307(g)(3)(B) submitted SOAP notes support the services were rendered as billed. Per Rule 134.202(c)(6) reimbursement is recommended and the Carrier shall assign a payment amount.
- CPT Code 98943 for date of service 01/15/04, neither party submitted an EOB. Per Rule 134.204(c)(6) reimbursement is recommended and the Carrier shall assign a payment amount.
- CPT Code 97110 for dates of service 09/15/03, 09/22/03, and 11/10/03 denied as “N”. 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. Additional reimbursement not recommended.
- CPT Code 99215-25 for date of service 09/22/03 denied as “N”. Per Rule 133.307(g)(3)(B) submitted SOAP notes support the services were rendered as billed. Per Rule 134.202(b) and the Medicare Fee Schedule reimbursement in the amount of \$143.78 is recommended.
- CPT Code 97140-59 (2 units) for date of service 01/15/04. Neither party submitted an EOB. Per Rule 133.307(g)(3)(A) the requestor did not submit convincing evidence of request for reconsideration; therefore, reimbursement is not 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 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 Order is applicable to dates of service 05/12/030 through 02/16/04 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 Decision is hereby issued this _____ day _____ 2005.

Medical Dispute Resolution Officer
Medical Review Division

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 8-28-01 through 12-28-01 in this dispute.

This Order is hereby issued this _____ day of _____ 2005.

r, Manager
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO Decision

MAXIMUS

July 22, 2004

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2800-01

TWCC #:

Injured Employee:

Requestor: Dr. Joseph P. Viernow

Respondent: Flahive Ogden & Latson

MAXIMUS Case #: TW04-0275

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 22 year-old female who sustained a work related injury on 5/___/03. The initial diagnoses for this patient have included closed dislocation of wrist, unspecified part, sprain of unspecified site of wrist, other lesion of median nerve, muscle spasm of associated areas, and carpal tunnel syndrome. The patient was treated with conservative care initially. On 3/3/04 the patient underwent a right 1st DEC release. Postoperatively the patient was treated with further physical therapy.

Requested Services

Computer data analysis, prolonged physician service 1st hour, chiropractic manipulative treatment spinal, manual therapy technique, therapeutic exercises, unlisted modality, unlisted procedure-nervous system, ultrasound, application of modality to 1> areas ultraviolet, level IV office visit, and medical records fee from 6/3/03 to 2/16/04.

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

Documents Submitted by Requestor:

1. FCE 5/6/04
2. SOAP notes 5/13/03 – 6/14/04
3. Operative note 3/3/04

Documents Submitted by Respondent:

1. Partial Peer review 12/14/03

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 chiropractor reviewer noted that this case concerns a 22 year-old female who sustained a work related injury on 5/11/03. The MAXIMUS chiropractor reviewer also noted that the patient was initially treated with conservative care and subsequently underwent surgery on 3/3/04. The MAXIMUS chiropractor reviewer further noted that postoperatively the patient was treated with physical therapy. The MAXIMUS chiropractor reviewer explained that although the patient did not respond favorably to treatment and eventually required surgery, the treatment rendered to this patient was medically necessary. Therefore, the MAXIMUS chiropractor consultant concluded that the computer data analysis, prolonged physician service 1st hour, chiropractic manipulative treatment spinal, manual therapy technique, therapeutic exercises, unlisted modality, unlisted procedure-nervous system, ultrasound, application of modality to 1> areas ultraviolet, level IV office visit, and medical records fee from 6/3/03 to 2/16/04 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department