

MDR Tracking Number: M5-04-3069-01

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 2-14-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of 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** 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 office visit and X-Ray cervical spine complete on 3-19-02, the office visit, joint mobilization, myofascial release, electric shock unit, and manual traction from 4-30-02 through 5-3-02 were **found** to be medically necessary. The x-ray, wrist complete, min 3 views performed on 3-19-02, the physical performance test on 5-1-02, the muscle testing on 5-3-02 and the therapeutic exercises on 4-30-02, 5-2-02, and 5-3-02 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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.

On 9-10-04 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.

Regarding dates of service 3-25-02 through 4-26-02 which were denied with an "E" – Entitlement, Noncompensable. The Appeals decision of 7-25-03 ruled "The compensable injury of 1-29-02 does not extend to and include right Carpal Tunnel Syndrome." Treatment for Carpal Tunnel Syndrome where reimbursement was not ordered can be billed by the Requestor in accordance with Texas Labor Code 413.042(a)(1). However, review of the HCFA 1500's for dates of service 3-25-02 through 4-26-02 reveals that the requestor billed with the following diagnosis codes: 722.71 – cervical disc disorder, 724.9- nerve root compressible, 354.0 – carpal tunnel syndrome, and 842.0 – wrist sprain. Therefore, these services are reimbursable since the doctor treated the cervical disc disorder in combination with the other parts of the body on each date of service. Recommend reimbursement for these services as follows:

CPT code 99213 – 3-25-02, 3-26-02, 4-2-02, 4-3-02, 4-4-02, 4-8-02, 4-9-02, 4-10-02, 4-11-02, 4-16-02, 4-17-02, 4-18-02, 4-19-02, 4-23-02, 4-24-02, 4-25-02 and 4-26-02: **Recommend reimbursement of \$816.00. (\$48.00 x 17)**

CPT code 99265 – 3-25-02, 3-26-02, 4-2-02, 4-3-02, 4-4-02, 4-8-02, 4-9-02, 4-10-02, 4-11-02, 4-16-02, 4-17-02, 4-18-02, 4-19-02, 4-23-02, 4-24-02, 4-25-02 and 4-26-02: **Recommend reimbursement of \$731.00. (\$43.00 x 17)**

CPT code 99250 – 3-25-02, 3-26-02, 4-2-02, 4-3-02, 4-4-02, 4-8-02, 4-9-02, 4-10-02, 4-11-02, 4-16-02, 4-17-02, 4-18-02, 4-19-02, 4-23-02, 4-24-02, 4-25-02 and 4-26-02: **Recommend reimbursement of \$731.00. (\$43.00 x 17)**

CPT code 99122 – 3-25-02, 3-26-02, 4-2-02, 4-3-02, 4-4-02, 4-8-02, 4-9-02, 4-10-02, 4-11-02, 4-16-02, 4-17-02, 4-18-02, 4-19-02, 4-23-02, 4-24-02, 4-25-02 and 4-26-02: **Recommend reimbursement of \$595.00. (\$35 x 17)**

CPT code 97110 – 3-26-02, 4-2-02, 4-3-02, 4-4-02, 4-8-02, 4-9-02, 4-10-02, 4-11-02, 4-16-02, 4-17-02, 4-18-02, 4-19-02, 4-23-02, 4-24-02, 4-25-02 and 4-26-02: 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 72141-27-22 – Extended MRI-Cervicle for date of service 4-4-02 - **Recommend reimbursement of \$756.00.**

CPT code 95851 for date of service 4-8-02 - **Recommend reimbursement of \$108.00. (\$36.00 x 3)**

CPT code 95999 for date of service 4-11-02 – Neither the Requestor not the Carrier submitted EOB's. There is no "convincing evidence of the carrier's receipt of the provider request for an EOB" according to 133.307 (e)(2)(B). **Reimbursement not recommended.**

This Findings and Decision is hereby issued this 29th day of November, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

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 3-19-02 through 5-3-02 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 Order is hereby issued this 29th day of November , 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

September 10, 2004

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

**NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter**

**RE: MDR Tracking #: M5-04-3069-01
TWCC #:
Injured Employee:
Requestor: Central Dallas Rehab
Respondent: North American Specialty Ins.
MAXIMUS Case #: TW04-0313**

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 male who sustained a work related injury on _____. The patient reported that while at work he sustained a repetitive motion injury to his neck. A MRI of the cervical spine performed on 4/4/02 indicated a normal exam. On 5/15/02 the patient underwent a neurodiagnostic study. The diagnoses for this patient have included cervical sprain with trigger points, suboccipital neuritis, and rule out right carpal tunnel syndrome. Treatment for this patient's condition has included therapeutic exercises, manual procedures, joint mobilization, and manual traction.

Requested Services

Office visit 99203-99213, x-ray cervical spine complete 72052-wp, x-ray wrist complete, min 3 views 73110-wp, therapeutic exercises 97110, joint mobilization 97265, myofascial release 97250, manual traction 97122, physical performance test 97750, neuromuscular stimulator, electric shock unit E0745, and muscle testing 97750-mt on 3/19/02, and 4/30/02 through 5/3/02.

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

Documents Submitted by Requestor:

1. Office notes 7/22/02 and 8/19/02
2. Neurodiagnostic study report 5/15/02
3. MRI report 4/4/02
4. Office notes 3/19/02 – 5/3/02

Documents Submitted by Respondent:

1. Peer Review 4/24/02
2. Office notes 3/19/02 – 5/3/02

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 male who sustained a work related injury to his neck on _____. The MAXIMUS chiropractor reviewer also noted that the patient had been treated with therapeutic exercises, manual procedures, joint mobilization, and manual traction. The MAXIMUS chiropractor reviewer indicated that treatment and evaluation of the neck area and x-rays of the cervical spine are appropriate. The MAXIMUS chiropractor reviewer noted that the patient's hand injury was not a compensable injury and therefore no treatment would be allowed for this. The MAXIMUS chiropractor reviewer explained that 6 weeks of treatment to the neck and cervical area were medically necessary. The MAXIMUS chiropractor reviewer also explained that there is no supporting documentation that demonstrates what one on one therapy was performed and for what body part. The MAXIMUS chiropractor reviewer indicated that the documentation provided does not support the need for the physical testing performed on 5/1/02 and 5/3/02. Therefore, the MAXIMUS chiropractor

consultant concluded that the office visit (99203) and x-ray cervical spine complete (72052-wp) on 3/19/02 were medically necessary to treat this patient's condition and that the x-ray, wrist complete, min 3 views (73110-wp) performed on 3/19/02 were not medically necessary to treat this patient's condition. The MAXIMUS chiropractor consultant also concluded that the physical performance test (97750) on 5/1/02, the muscle testing (97750-mt) on 5/3/02, and the therapeutic exercises (97110) on 4/30/02, 5/2/02 and 5/3/02 were not medically necessary to treat this patient's condition.

The MAXIMUS chiropractor consultant further concluded that the office visit (99213), joint mobilization (97265), myofascial release (97250), electric shock unit (E0745), and manual traction (97122) from 4/30/02 through 5/3/02 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department