

MDR Tracking Number: M5-04-3167-01

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 5-21-04.

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** 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 IRO has determined that the office visits with manipulation, ultrasound, hot/cold packs, electrical stimulation, myofascial release, therapeutic exercises, mechanical traction, DME (wrist splint extension), manual therapy, chiropractic manipulation, muscle testing, paraffin bath, and office visits from 6/02/03 through 11/14/03 were medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

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 September 15, 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 99080-73** for date of service 8/29/03: The carrier denied this code with a V for unnecessary medical treatment based on a peer review, however, per Rule 129.5, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, **reimbursement is recommended** in the amount of \$15.

CPT code 97140 for date of service 8/05/03: The carrier denied this service with "G", unbundling, however, the carrier didn't specify which service this was global to. Therefore, it will be reviewed according to the Medicare Fee Schedule. Reimbursement is recommended in the amount of \$30.90.

CPT code A9300 for date of service 11/26/03: The carrier denied this service with "G", unbundling, however, the carrier didn't specify which service this was global to. No MAR was listed, and the carrier did not submit relative values for this service. Therefore, reimbursement is recommended according to Rule 134.202 (C ) (6).

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 as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- in accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c)(1) and (6);
- 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 6/02/03 through 11/26/03 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 Decision and Order is hereby issued this 1<sup>st</sup> day of November 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc  
Enclosure: IRO decision

September 16, 2004

Ms. Rosalinda Lopez  
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 #: M5-04-3167-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Neuromuscular Institute of Texas-CC**  
**Respondent:** **c/o Hammerman & Gainer**  
**MAXIMUS Case #: TW04-0320**

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 female who sustained a work related injury on \_\_\_\_\_. The patient had been treated on and off for complaints of pain due to a repetitive motion injury. On 6/2/03 the patient presented with complaints of bilateral upper extremity pain as well as right shoulder and cervical spine pain. The patient began conservative therapy treatments that included electrical stimulation, manipulations, ultrasound, and hot/cold packs. On 9/10/03 the patient underwent right carpal tunnel release. On 9/19/03 the patient began a course of postoperative rehabilitation and therapy that included interferential stimulation, heat, soft tissue mobilization and ultrasound. On 11/19/03 the patient underwent left carpal tunnel release. On 12/1/03 the patient began a course of postoperative rehabilitation and therapy followed by a work hardening program that began on 2/9/04.

#### Requested Services

Office visits with manipulation, ultrasound, hot/cold packs, electrical stimulation, myofascial release, therapeutic exercises, mechanical traction, DME-wrist splint extension, manual therapy, chiropractic manipulation, muscle testing, paraffin bath and office visits from 6/2/03 through 11/14/03.

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

##### *Documents Submitted by Requestor:*

1. Consults and Office visits 10/16/02 – 6/21/04
2. Treatment Logs 9/13/02 – 3/5/04
3. Treatment notes 7/29/03 – 4/20/04

*Documents Submitted by Respondent:*

1. Position statement 7/29/04
2. Preliminary Chiropractic Modality Review 6/12/02, 4/21/03, 12/3/03, 3/16/04
3. Treatment logs 6/26/03 – 1/30/04

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 female who sustained a work related injury on \_\_\_\_\_. The MAXIMUS chiropractor reviewer indicated that the patient had ongoing symptoms of a repetitive stress disorder that became severe in May of 2003. The MAXIMUS chiropractor reviewer noted that the patient started a concentrated program of treatment on 6/2/03. The MAXIMUS chiropractor reviewer also noted that after several treatments and a referral to an orthopedist it was determined that surgery would be the best option. The MAXIMUS chiropractor reviewer explained that treatment was stopped on 8/29/03 and that the patient underwent surgery on 9/10/03 followed by postoperative therapy. The MAXIMUS chiropractor reviewer indicated that it is important to try a 6-8 week course of conservative care before surgery is considered. The MAXIMUS chiropractor reviewer explained that postoperative therapy is medically necessary to promote healing. The MAXIMUS chiropractor reviewer also explained that although the outcome was poor in both instances, the care is considered medically necessary as related to acceptable standards of care.

Therefore, the MAXIMUS chiropractor consultant concluded that the office visits with manipulation, ultrasound, hot/cold packs, electrical stimulation, myofascial release, therapeutic exercises, mechanical traction, DME-wrist splint extension, manual therapy, chiropractic manipulation, muscle testing, paraffin bath and office visits from 6/2/03 through 11/14/03 were medically necessary to treat this patient's condition.

Sincerely,  
**MAXIMUS**

Elizabeth McDonald  
State Appeals Department