MDR Tracking Number: M5-04-3252-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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 05-27-04.

The IRO reviewed office visits on dates of service 07-01-03, 07-02-03, 07-08-03, 07-10-03, 07-15-03, 07-16-03, 07-17-03, 07-21-03, 07-24-03, 07-29-03, 07-30-03 and 07-31-03 that were denied based upon "U".

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.

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 07-14-04, 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 codes 97250, 97265, 97035, 97014 and HCPCS code A4556 date of service 06-30-03 denied with denial code "N" (not appropriately documented/doc submitted does not state this code was provided. No soap notes). Documentation submitted by the requestor does not support services billed. No reimbursement recommended.

CPT codes 97250, 97035 and 97014 date of service 07-01-03 are listed on the table of disputed services. The respondent submitted an EOB reflecting payment has been made for these services via check number 000099646, therefore, these services are no longer in dispute.

CPT code 97265 date of service 07-01-03 denied with denial code "N" (not appropriately documented/payment reduced because documentation submitted does not state code was provided). Documentation submitted by the requestor does not support services billed. No reimbursement recommended.

CPT code 99213 date of service 08-06-03 is listed on the table of disputed services. The respondent submitted an EOB reflecting payment has been made for this service via check number 000104705, therefore this service is no longer in dispute.

CPT code 97014 dates of service 08-06-03 and 08-08-03 denied with denial code "G" (payment is being denied because charge was included in another billed procedure. Code is not for electric stimulation therapy). The requestor resubmitted the services for reconsideration with the proper code (G0283). Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **$29.82 ($11.93 X 125% = $14.91 X 2 DOS).**

CPT code 99213 date of service 08-08-03 denied with denial code "N" (not appropriately documented). Per Rule 133.304(c) "The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section". Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **$59.00 ($47.20 X 125%).**

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(1)(8) for dates of service through July 31, 2003 and in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), 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 07-01-03 through 08-08-03 in this dispute.

This Findings and Decision and Order are hereby issued this 17th day of February 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

August 27, 2004

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 #: M5-04-3252-01
TWCC #:
Injured Employee:
Requestor: Neuromuscular Institute of Texas-PA
Respondent: City of San Antonio c/o Harris & Harris
MAXIMUS Case #: TW04-0338

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 54 year-old male who sustained a work related injury on ___. The patient reported that while at work as a firefighter, he injured his left shoulder while attempting to lift another firefighter up into an attic space. The diagnoses for this patient have included left supraspinatus tear and a/c sprain. Treatment for this patient's condition has included ultrasound, joint mobilization, soft tissue mobilization, and heat.

Requested Services

Office visits (99213) on 7/1/03, 7/2/03, 7/8/03, 7/10/03, 7/15/03, 7/16/03, 7/17/03, 7/21/03, 7/24/03, 7/29/03, 7/30/03, &7/31/03.

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

Documents Submitted by Requestor:

1. Consults and Office visits 6/30/03 – 12/22/03
2. Treatment Logs 7/10/03 – 12/19/03
3. Initial Eval & Daily Logs 9/8/03 – 10/9/03
4. Work Hardening 10/28/03 – 12/8/03

Documents Submitted by Respondent:

1. No medical records submitted

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 54 year-old male who sustained a work related injury to his left shoulder on ___. The MAXIMUS chiropractor reviewer indicated that the patient began treatment on 6/30/03 that consisted of an office visit (99213) on each date in question plus therapies. The MAXIMUS chiropractor reviewer explained that the office visit is required for evaluating the patient's progress and determining the appropriate form of care to be delivered for the best possible outcome. The MAXIMUS chiropractor reviewer also explained that this progress was documented in the subjective and objective part of the daily treatment logs. Therefore, the MAXIMUS chiropractor consultant concluded that the office visits (99213) on 7/1/03, 7/2/03, 7/8/03, 7/10/03, 7/15/03, 7/16/03, 7/17/03, 7/21/03, 7/24/03, 7/29/03, 7/30/03, &7/31/03 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department