

MDR Tracking Number: M5-04-3407-01

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 6-7-04.

In accordance with Rule 133.307 (d), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 11/20/03, therefore the following date(s) of service are not timely and are not eligible for this review: 6-4-03 through 6-6-03.

Per a facsimile dated 10-01-04 the requester withdrew CPT Code 98941 for date of service 10-7-03 and and CPT Code 99455 for date of service 10-31-03.

CPT Code 99455 for date of service 10-31-03 was reviewed in the IRO decision. However, as noted above, this service was withdrawn from the dispute.

In accordance with 413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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.

The office visits, therapeutic exercises, chiropractic manipulative treatment, spinal one to two regions, special reports, chiropractic manipulative treatment, extra-spinal/one or more regions, chiropractic manipulative treatment, spinal three to four regions, work related or medical disability examination by the treating physician and rental of electrical nerve stimulation device from 6-16-03 through 9-22-03 were 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 fees were not the only fees involved in the medical dispute 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 10-1-04 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 CPT Code 97110 for dates of service 7-2-03, 7-7-03, 7-9-03, 7-11-03 and 7-14-03 and 7-18-04: 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.**

Regarding CPT Code 99213 for dates of service 7-2-03, 7-7-03, 7-9-03, 7-11-03 and 7-14-03, 7-25-04, and 7-29-03: These services were billed by the requestor and denied by the carrier with an "O" denial code. These dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$336.00.**

Regarding CPT Code 99214 for date of service 7-23-04: This service was billed by the requestor and denied by the carrier with an "O" denial code. These dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$71.00.**

Regarding CPT Code 98943 for dates of service 8-4-03 and 8-18-03: This code reports a procedure, service or supply that is not covered or valid for Medicare. Rule 134.202 (b) states: "for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." **Therefore, reimbursement is not recommended.**

Regarding CPT Code 98940 for dates of service 8-4-03 and 8-18-03: This service was billed by the requestor and denied by the carrier with an "O" denial code. These dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$63.36.**

Pursuant to 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) for dates of service through July 31, 2003;
- in accordance with Medicare program reimbursement methodologies for dates of service after 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 Order is applicable for dates of service 6-4-03 through 10-31-03 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 15th day of October, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da
Enclosure: IRO decision

October 15, 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 #: M5-04-3407-01
TWCC #:
Injured Employee:
Requestor: TLC Chiropractic Center
Respondent: Royal & Sun Alliance
MAXIMUS Case #: TW04-0343

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 26 year-old female who sustained a work related injury on _____. The patient reported that while at work she slipped on an onion and fell to the ground injuring her left knee, right leg and low back. A MRI of the lumbar spine dated 5/27/03 revealed disc herniation at the L5-S1 level. A MRI of the left knee performed on 9/15/03 showed an ACL strain, low-grade chondromalacia, and a small effusion. An EMG/NCV performed on 5/19/03 showed abnormalities demonstrating latency at L4-L5 and L5-S1 on the right. Treatment for this patient's condition has included ice, electrical muscle stimulation, soft tissue manipulation, and chiropractic adjustments.

Requested Services

Office visits, therapeutic exercises, chiropractic manipulative treatment, spinal one to two regions, special reports, chiropractic manipulative treatment, extra-spinal one or more regions, chiropractic manipulative treatment, spinal three to four regions, work related or medical disability examination by the treating physician, and rental of electrical nerve stimulation device from 6/16/03 through 10/31/03.

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

Documents Submitted by Requestor:

1. MRI report 5/27/03, 9/15/03
2. Incident Report _____
3. Chiropractic Neurological Exam 3/26/03 and 7/23/03
4. SOAP notes 3/26/03 – 10/29/03
5. EMG report 5/19/03
6. FCE 6/3/03

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 overturned.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a 26 year-old female who sustained a work related injury on _____. The MAXIMUS chiropractor reviewer also noted that the treatment for this patient's condition has included ice, electrical muscle stimulation, soft tissue manipulation, and chiropractic adjustments. The MAXIMUS chiropractor reviewer explained that the patient had numerous injuries. The MAXIMUS chiropractor reviewer also explained that the

patient was pregnant and that this further complicated the treatment process. The MAXIMUS chiropractor reviewer further explained that the patient responded well to the treatment rendered. Therefore, the MAXIMUS chiropractor consultant concluded that the office visits, therapeutic exercises, chiropractic manipulative treatment, spinal one to two regions, special reports, chiropractic manipulative treatment, extra-spinal one or more regions, chiropractic manipulative treatment, spinal three to four regions, work related or medical disability examination by the treating physician, and rental of electrical nerve stimulation device from 6/16/03 through 10/31/03 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department