

MDR Tracking Number: M5-04-3546-01

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, 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 06-17-04.

The IRO reviewed electrical stimulation, massage therapy, chiropractic manipulation (98943 and 98940), paraffin bath, therapeutic exercises, hot/cold pack therapy, ultrasound therapy and office visits (99213, 99214, 99215) rendered from 09-02-03 through 01-30-04 that were denied based upon "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.

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 07-23-04, 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.

Review of CPT codes 99214, 98943, 97302, 97124, 97010, and 97032 dates of service 09-26-03 through 12-22-03 revealed that neither the requestor nor the respondent submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement recommended.

Review of CPT code 97110 dates of service 09-14-03 through 12-22-03 (11 DOS) revealed that neither the requestor nor the respondent submitted copies of EOBs. 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.

This Findings and Decision is hereby issued this 17th day of December 2004.

Debra L. Hewitt
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 09-02-03 through 01-30-04 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 Order is hereby issued this 17th day of December 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh
Enclosure: IRO Decision

November 18, 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 B

**RE: MDR Tracking #: M5-04-3546-01
TWCC #:
Injured Employee:
Requestor: Montana Rehab Ctr., Inc.
Respondent: Insurance Co. of the State of PA
MAXIMUS Case #: TW04-0359**

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 37 year-old female who sustained a work related injury on _____. A MRI of the right wrist performed on 8/8/03 showed flexor tenosynovitis and carpal tunnel syndrome. On 9/9/03 the patient underwent an EMG/NCV. The diagnoses for this patient have included right carpal tunnel syndrome, radial nerve dysfunction right wrist, and De Quervain's tenosynovitis right wrist. On 10/14/03 the patient underwent a right carpal tunnel release, superficial branch radial nerve neurolysis, and first dorsal compartment release. Postoperatively the patient was treated with physical therapy and rehabilitation.

Requested Services

Electrical stimulation, massage therapy, chiropractic manipulation (98943 and 98940), paraffin bath, therapeutic exercises, hot/cold pack, ultrasound therapy and office visits (99213, 99214, 99215) from 9/2/03 through 1/30/04.

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

Documents Submitted by Requestor:

1. MRI report 8/8/03
2. Orthopedic Notes 8/22/03 – 5/4/04
3. EMG report 9/9/03

Documents Submitted by Respondent:

1. Behavioral Evaluation of Pain 3/1/04
2. Physical Performance Evaluation 8/19/03
3. FCE 2/6/04
4. Montana Rehabilitation Center Initial Report 7/24/03
5. Office notes 8/1/03 – 9/16/03

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 37 year-old female who sustained a work related injury to her right wrist on _____. The MAXIMUS chiropractor reviewer also noted that the diagnoses for this patient have included right carpal tunnel syndrome, radial nerve dysfunction right wrist, and DeQuervain's tenosynovitis right wrist. The MAXIMUS chiropractor reviewer further noted that the treatment for this patient's condition has included right carpal tunnel release, superficial branch radial nerve neurolysis, and first dorsal compartment release followed by postoperative rehabilitation. The MAXIMUS chiropractor reviewer explained that this patient's condition is difficult to treat preoperatively and even more difficult to treat post operatively. The MAXIMUS chiropractor reviewer also explained that postoperative therapy/rehabilitation was medically necessary to treat this patient's condition to help facilitate recovery. The MAXIMUS chiropractor reviewer further explained that the patient responded reasonably well to the treatment rendered. Therefore, the MAXIMUS chiropractor consultant concluded that the electrical stimulation, massage therapy, chiropractic manipulation (98943 and 98940), paraffin bath, therapeutic exercises, hot/cold pack, ultrasound therapy and office visits (99213, 99214, 99215) from 9/2/03 through 1/30/04 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department