

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-3086.M5**

MDR Tracking Number: M5-04-3871-01

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 07-11-04.

The IRO reviewed therapeutic exercises and office visits rendered from 02-18-04 through 03-10-04 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 08-05-04, 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.

No explanation of benefits for CPT code 97110 for dates of service 10-28-03 and 02-27-04 was submitted from the respondent or the requestor. No reimbursement is recommended per the RATIONALE listed below.

**RATIONALE:** Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings 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 (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

The requestor nor the respondent submitted an explanation of benefits for CPT code 99213 for date of service 01-27-04. Reimbursement in the amount of \$67.25 per the Medical Fee Guideline effective 08-01-03 is recommended.

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 date of service 01-27-04 in this dispute.

This Findings and Decision and Order are hereby issued this 27<sup>th</sup> day of September 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh  
Enclosure: IRO Decision

September 10, 2004

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 #: M5-04-3871-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: West Belt Medical**  
**Respondent: Travelers**  
**MAXIMUS Case #: TW04-0380**

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 39 year-old male who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work he injured his left wrist, right knee, low back area and neck area when he fell from his fork lift. A MRI of the cervical spine performed on 11/26/02 indicated a minimal kyphotic curvature at the C3-4 level, right sided disc protrusion measuring 3-4mm, uncovertebral joint arthropathy on the right causing severe foraminal narrowing and compromise of the right C4 nerve root, and at the C6-7 level uncovertebral joint arthropathy on the right with mild compromise of the right C7 nerve root. Diagnoses for this patient's condition have included cervical radiculopathy, bilateral secondary to a C3-4 herniated disc. Treatment for this patient's condition has included ultrasound, traction, electrical stimulation and active stretching.

### Requested Services

Therapeutic exercises and office visits 2/18/04 through 3/10/04.

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

#### *Documents Submitted by Requestor:*

1. Consultation 4/11/03
2. MRI report 11/26/02
3. FCE 6/25/04
4. Office notes 9/3/03 – 3/19/04

#### *Documents Submitted by Respondent:*

1. Required Medical Exam 8/14/03

### Decision

The Carrier's denial of authorization for the requested services is upheld.

### Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a 40 year-old male who sustained a work related injury to his left wrist, right knee, lower back and neck on \_\_\_\_\_. The MAXIMUS physician reviewer indicated that the patient had complaints of low back pain, carpal

tunnel syndrome, knee pain, neck pain and upper back pain. The MAXIMUS physician reviewer noted that treatment throughout this patient's care has consisted of various exercises, manipulation and, occasionally, physical therapy modalities. The MAXIMUS physician reviewer also noted that the findings throughout care have consisted of fixations, restricted motions (although no arcs of motion are given) and muscle spasms. The MAXIMUS physician reviewer indicated that the patient was examined on 10/7/03 and found to have almost normal cervical ranges of motion and lumbar motion, reduced wrist motions, muscle spasms and a couple of positive orthopedic tests. The MAXIMUS physician reviewer indicated that while an initial course of chiropractic care was medically necessary, long-term ongoing care was not. The MAXIMUS physician reviewer explained that the patient had the same complaints, same findings and essentially, the same treatment rendered for seven months. The MAXIMUS physician reviewer indicated that the patient had not received significant lasting benefit from chiropractic care. The MAXIMUS physician reviewer explained that for medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time frame. The MAXIMUS physician reviewer also explained that the type, frequency and duration of services must be reasonable and consistent with the standards of practice in the chiropractic community. The MAXIMUS physician reviewer indicated that additional treatment might be needed if objective findings and benefit can be demonstrated. The MAXIMUS physician reviewer explained that there is no indication in the documents provided that the patient continued to receive any significant lasting objective benefit.

Therefore, the MAXIMUS physician consultant concluded that the Therapeutic exercises and office visits 2/18/04 through 3/10/04 were not medically necessary to treat this patient's condition.

Sincerely,  
**MAXIMUS**

Elizabeth McDonald  
State Appeals Department