MDR Tracking Number: M5-04-3905-01

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. This dispute was received on 7-14-04.

The IRO reviewed office visits, muscle testing, ROM measurements, physical review of motion tests, ultrasound therapy, unusual physician travel, therapeutic exercises, gait training, manual therapy and electric stimulation rendered from 8-6-03 to 1-19-04 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO concluded that office visits, muscle testing, ROM measurements, physical review of motion test, ultrasound therapy, unusual physician travel, therapeutic exercises, gait training, manual therapy, and electric stimulation from 8-6-03 through 9-2-03 were medically necessary. All other services were found to be not medically necessary.

On this basis, the total amount recommended for reimbursement ($94.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On August 24, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services identified below. The requestor submitted convincing evidence that supports bills were

submitted for audit. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-2-03	96004	$144.00	$0.00	G	$132.56	Physc. Review of Motion Tests	Reviewing the FC test is global to test. The 12-2-03 office visit does not document a separate procedure, reimbursement is not recommended.
12-2-03	97750FC (16)	$592.00	$0.00	N	$33.41 X 16 = $534.56	CPT Code Descriptor	Report supports billed service - MAR reimbursement of $534.56 is recommended.
11-24-03	97545WH	$102.40	$0.00	No EOB	$51.20/hr X2 = $102.40	CPT Code Descriptor	MAR reimbursement of $102.40 is recommended.
11-24-03	97546WH	$307.20	$0.00	No EOB	$51.20/hr X6 = $307.20	CPT Code Descriptor	MAR reimbursement of $307.20 is recommended.
10-13-03	G0283	$34.00	$0.00	D	$14.91 X 2 = $29.82	CPT Code Descriptor	This is not a duplicate of any service provided on this date. MAR reimbursement of $29.82 is recommended.
10-13-03	99213	$67.00	$0.00	D	$67.00	CPT Code Descriptor	This is not a duplicate service rendered on this date. MAR reimbursement of $59.00 is recommended.
10-9-03	99080	$15.00	$0.00	F	$15.00	Rule 129.5(d)	A report to support billing and compliance with statute, was not submitted, no reimbursement is recommended.
9-15-03	99213	$67.00	$0.00	F	$59.00	CPT Code Descriptor	MAR reimbursement of $59.00 is recommended.
9-11-03	99213	$67.00	$0.00	MD	$59.00	CPT Code Descriptor	MAR reimbursement of $59.00 is recommended.
9-10-03	97010	$11.00	$0.00	MD	NRF	CPT Code Descriptor	This service is not reimbursable per Medicare.
8-18-03 8-20-03 8-21-03 8-25-03 8-27-03 9-8-03 9-11-03 9-15-03 9-17-03	97110	$144.00	$97.92	F	$32.64/15 min	CPT Code Descriptor	See Rationale below
8-22-03	97110	$144.00	$97.89	F	$32.64/15 min		
8-11-03	99213	$67.00	$0.00	JM	$59.00	CPT Code	MAR reimbursement of $59.00 X 8

8-12-03 8-15-03 8-18-03 8-20-03 8-22-03 8-25-03 8-27-03						Descriptor	= $472.00 is recommended.
8-15-03	95851	$72.00	$0.00	G	$30.61		
8-7-03	97010	$11.00	$0.00	No EOB	NRF	CPT Code Descriptor	This service is not reimbursable per Medicare.
8-7-03	99213	$67.00	$0.00	Y	$59.00	CPT Code Descriptor	MAR reimbursement of $59.00 is recommended.
8-7-03	G0283	$34.00	$0.00	No EOB	$14.91 X 2 = $29.82	CPT Code Descriptor	Reimbursement of $34.00 is recommended.
8-6-03 8-27-03 9-2-03 9-3-03 9-8-03 9-11-03 10-6-03	97010	$11.00	$0.00	NC	NRF	CPT Code Descriptor	This service is not reimbursable per Medicare.
8-4-03 9-2-03 9-10-03	99213	$67.00	$0.00	N	$59.00	CPT Code Descriptor	8-4-03 report does not document 2/3 key components, therefore, no reimbursement is recommended. The requestor supports billed service per MFG for the remaining two dates. $59.00 X 2 = $118.00 is recommended.
7-31-03	95851	$36.00	$0.00	G	$36.00	ROM Testing	ROM testing is not global to office visit or therapy rendered on this date. Reimbursement of $36.00 is recommended.
7-28-03	A4556	$16.00	$0.00	G	DOP	Electrodes	Office visit report does not indicate what the electrodes were used for. Electric stimulation was rendered on this date, electrodes to administer the electric stimulation would be global to the therapy. No reimbursement is recommended.
7-21-03	99201MP	$36.00	$0.00	No EOB	$34.00	CPT Code Descriptor	MAR reimbursement of $34.00 is recommended.
TOTAL							The requestor is entitled to reimbursement of $1899.80

Rationale for 97110:

Recent review of disputes involving one-on-one 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 therapy notes for these dates of service do not support any clinical (mental or physical) reason as to why the patient could not have performed these exercises in a group setting, with supervision, as opposed to one-to-one therapy. The Requestor has failed to submit documentation to support reimbursement in accordance with Rule 134.202 and 133.307(g)(3). Therefore, reimbursement is not recommended.

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 7-21-03 through 1-19-04 in this dispute.

This Order is hereby issued this 14th day of January 2005.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

October 13, 2004

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3905-01
TWCC #:
Injured Employee:
Requestor: Alpine Healthcare, LP
Respondent: Texas Mutual Insurance Co.
MAXIMUS Case #: TW04-0388

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 49 year-old male who sustained a work related injury on ___. The patient reported that while at work he was struck in the right arm with a piece of water meter cover causing him to fall to the ground and injure his back. The patient reportedly

underwent an EMG/NCV study that revealed an abnormal study due to the findings of right cubital tunnel syndrome, right ulnar neuritis at the wrist, and bilateral lumbosacral radiculitis. On 8/7/03 the patient underwent a MRI of the lumbar spine that was reported to have shown posterior disc bulge extending laterlly with associated disc dehydration at the L3-L3 and L3-L4 level, and a left paracentral disc protrusion L4-L5 with narrowing of the left neural canal. The diagnoses for this patient included intevertebral disc disorder with myelopathy, lumbar region, open wound of upper arm, pain in joint involving upper arm, and fracture of unspecified part of lower end of humerus, open. Treatment for this patient's condition has included conservative therapy consisting of ultrasound, therapeutic exercises, manual therapy and electrical stimualation.

Requested Services

Office outpatient (99213), muscle testing (95833), ROM measurements (95851), physical review of motion tests (96004), ultrasound therapy (97035), unusual physician travel (99082), therapeutic exercises (97110), gait training (97116), manual therapy (97140), and electric stimulation (97014) from 8/6/03 through 1/19/04.

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

Documents Submitted by Requestor:

1. Treating Doctor Position Statement 8/24/04
2. SOAP notes 7/28/03 – 1/19/04
3. Ergos Evaluation Summary Report 12/2/03

Documents Submitted by Respondent:

1. No documents submitted

Decision

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

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a 49 year-old male who sustained a wok related injury to his right arm on ___. The MAXIMUS chiropractor reviewer indicated that the treatment for this patient's condition began 7/21/03 and continued through at least 1/19/04 and consisted of therapeutic exercises, heat, electrical stimulation, and ultrasound therapy. The MAXIMUS chiropractor reviewer noted that the patient had complaints of lower back pain and radiculitis, upper arm pain, thoracic pain and/or numbness and tingling in the fingers and that the findings throughout care consisted of palpation findings of tenderness or

pain, fixations and one positive orthopedic test, and range of motion (although no arcs of motion are given). The MAXIMUS chiropractor reviewer also noted that an examination performed on 12/2/03 indicated a normal evaluation except for abnormal deep tendon reflexes in the lower extremity and one positive orthopedic test. The MAXIMUS chiropractor reviewer explained that for medical necessity for ongoing care to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable timeframe. The MAXIMUS chiropractor reviewer indicated that a short course of chiropractic care (9-12 vistis) were reasonable (American College of Occupational and Environmental Medicine Guidelines) and that additional treatment could be required if objective benefit can be demonstrated. However, the MAXIMUS chiropractor reviewer explained that there is no indication in the documentation provided that the patient received significant lasting objective benefit.

Therefore, the MAXIMUS chiropractor consultant concluded that the office outpatient (99213), muscle testing (95833), ROM measurements (95851), physical review of motion tests (96004), ultrasound therapy (97035), unusual physician travel (99082), therapeutic exercises (97110), gait training (97116), manual therapy (97140), and electric stimulation (97014) from 8/6/03 through 9/02/03 were medically necessary to treat this patient's condition. However, the MAXIMUS chiropractor consultant further concluded that the Office outpatient (99213), muscle testing (95833), ROM measurements (95851), physical review of motion tests (96004), ultrasound therapy (97035), unusual physician travel (99082), therapeutic exercises (97110), gait training (97116), manual therapy (97140), and electric stimulation (97014) from 9/8/03 through 1/19/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department