

MDR Tracking Number: M5-05-0475-01

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 (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 10-06-04.

In accordance with Rule 133.308 (e)(1), 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 following date(s) of service are not timely and are not eligible for this review: 9-29-03 through 10-03-03.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the 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 the only issue** to be resolved. The physical medicine services, CPT codes 95900-nerve conduction study, 97124-massage, 97530-therapeutic activities, and 97110-therapeutic procedures from 9-29-03 through 12-31-03 **were found** to be medically necessary. CPT codes 95900-nerve conduction study, 97124-massage, 97530-therapeutic activities, and 97110-therapeutic procedures from 1-5-04 through 3-15-04 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. The amount due the requestor for the medical necessity items is \$573.06.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues 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.

CPT code 98941 on 11-3-03 and 11-5-03 and CPT code 99213 on 3-19-04 were withdrawn by the requestor. These services will not be a part of this review.

On 3-15-05, the Medical Review Division submitted a Notice to the 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 98940 on 12-1-03 and 12-03-03: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$60.28 (\$30.14 X 2).**

Regarding CPT Code 97124 on 11-19-03, 12-17-03, 12-31-03, 3-12-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$103.38 (\$25.70 X 3 + \$26.28).**

Regarding CPT code 97035 on 10-06-03: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$14.21.**

Regarding CPT Code G0283 on 10-06-03: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$14.91.**

Regarding 98941 on 10-06-03, 11-19-03 and 11-21-03: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$125.67 (\$41.89 X 3 DOS).**

Regarding CPT Code 97010 on 10-06-03: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). The Trailblazer Local Coverage Determination (LCD) states that code 97010 "is a bundled code and considered an integral part of a therapeutic procedure(s). Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment will not be made. Payment is included in the allowance for another therapy service/procedure performed. **Reimbursement not recommended.**

CPT code 97530 on 10-10-03 (2 units) was denied as "Y – Mutually exclusive procedures." Pursuant to Rule 133.304(c) "The explanation of benefits shall include the correct payments 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)." The instructions for the Payment Exception Codes state, "Y" should always be used in conjunction with "U" or "V". **Recommend reimbursement of \$65.92 (\$32.96 X 2 units).**

Regarding CPT Code 95831 on 11-03-03 (9 units): Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$247.77 (\$27.53 X 9 units).**

Regarding CPT Code 97110 on 11-05-03, 11-19-03, 11-21-03, 12-03-03: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). 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.**

CPT code 98941 on 11-07-03 was denied as "N - not appropriately documented." Requestor did not submit relevant documentation to support level of service or service rendered per 133.307(g)(3)(B). **Reimbursement not recommended.**

Regarding CPT Code 97530 on 11-19-03, 12-01-03, 12-03-03: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$98.88 (\$32.96 X 3 DOS).**

CPT code 95831 on 11-24-03, 1-8-04 and 2-26-04 was denied as "F – code used is inconsistent with description of services rendered." Requestor did not submit relevant documentation to support level of service or service rendered per 133.307(g)(3)(B). **Reimbursement not recommended.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling \$1,304.08 from 10-6-03 through 3-12-04 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or 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 Decision and Order is hereby issued this 2nd day of May, 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

December 13, 2004

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

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Determination 4/26/05**

**RE: MDR Tracking #: M5-05-0475-01
TWCC #: ____
Injured Employee: ____
Requestor: Allied Multicare Centers
Respondent: Texas Association of School Boards Risk Management Fund
MAXIMUS Case #: TW04-0486**

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 45 year-old female who sustained a work related injury on _____. The patient reported that while at work she injured her back when she slipped and fell. The patient underwent an MRI of the cervical spine on 8/19/03 that indicated posterior disc bulges or herniations at C5-6 and C6-7, no evidence of significant spinal stenosis, deviated thecal sac at C5-6, and facet bony and capsular hypertrophy at C6-7. An EMG/NCV performed on 9/29/03 revealed right radial sensory demyelination and neuropathy on right at C8 and T1 paraspinous muscles. The impression for this patient has included cervical intervertebral disc syndrome and cervical radiculitis/neuritis. Treatment for this patient's condition has included cryotherapy, manual manipulation, myofascial release, ultrasound and electric stimulation.

Requested Services

Physical Medicine Services, CPT codes 95900-nerve conduction study, 97124-massage, 97530-therapeutic activities, and 97110-therapeutic procedures from 10/7/03 through 3/19/04.

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

Documents Submitted by Requestor:

1. Initial Report 9/17/03
2. Subsequent Occupational Medicine Encounter 8/8/03, 8/14/03
3. EMG/NCV report 9/29/03
4. Independent Medical Evaluation 10/27/03
5. MMI rating 1/21/04
6. Daily Notes 9/24/03 – 3/22/04

Documents Submitted by Respondent:

1. No documentation 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 45 year-old female who sustained a work related injury to her back on _____. The MAXIMUS chiropractor also noted that the impression for this patient has included cervical intervertebral disc syndrome and cervical radiculitis/neuritis. The MAXIMUS chiropractor reviewer further noted that treatment for this patient's condition has included cryotherapy, manual manipulation, myofascial release, ultrasound and electric stimulation. The MAXIMUS chiropractor reviewer indicated that after 4 months of consistent treatment without documented improvement, treatment is no longer considered medically necessary. The MAXIMUS chiropractor reviewer explained that the documentation provided does not demonstrate that the patient improved with continued treatment. The MAXIMUS chiropractor reviewer indicated that on 12/17/03 the patient reported new symptoms of moderate nature. The MAXIMUS chiropractor also indicated that clinically, the treatment rendered to this patient did not work. Therefore, the MAXIMUS chiropractor consultant concluded that the physical medicine services, CPT codes 95900-nerve conduction study, 97124-massage, 97530-therapeutic activities, and 97110-therapeutic procedures from 10/7/03 through 12/31/03 were medically necessary. However, the MAXIMUS chiropractor consultant further concluded that the physical medicine services, CPT codes 95900-nerve conduction study, 97124-massage, 97530-therapeutic activities, and 97110-therapeutic procedures from 1/5/04 through 3/19/04 were not medically necessary to treat this patient's condition.

Sincerely,

MAXIMUS

Elizabeth McDonald

State Appeals Department