

MDR Tracking Number: M5-05-0575-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 10-20-04. The requestor submitted a letter of withdrawal for code 99213 for dates of service 6-28-04, 6-29-04, and 7-1-04 since the carrier paid.

The IRO reviewed range of motion, electrical stimulation, ultrasound, physical therapy treatment, and re-evaluation on 6-14-04 through 8-11-04.

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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 11-19-04, 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.

Code 97039-HP billed for date of service 6-24-04 had no EOB submitted by either party. Rule 133.307(e)(2)(B) states each copy of the request for medical dispute resolution shall include a copy of each explanation of benefits (EOB) or if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB. There was no convincing evidence of carrier receipt of request for an EOB. Per Rule 133.307 (e)(3)(B), upon receipt of the request, the respondent shall provide any missing information to include missing EOBs not submitted by the requestor. The respondent did not provide the missing EOB. Rule 133.1(a)(3)(C) states that a complete medical bill includes correct billing codes from Commission fee guidelines in effect on the date of service. The modifier –HP is invalid. Code 97039 requires a description of the modality and time if constant attendance. Therefore, no reimbursement can be recommended.

The above Findings and Decision is hereby issued this 30th day of December 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

December 28, 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 #: M5-05-0575-01
TWCC #:
Injured Employee:
Requestor: Town East Rehab
Respondent: Hartford Ins.
MAXIMUS Case #: TW04-0499

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 male who sustained a work related injury on _____. The patient reported that while at work, he slipped and fell causing an injury to his back. X-rays performed on 12/20/03 revealed normal findings. The report from an MRI of the lumbar spine performed on 1/26/04 indicated that the impression was mild central disc bulging at L5-S1 of approximately 3mms without significant thecal sac impingement, and no suggestion of spinal stenosis or disc herniation. The diagnoses for this patient have included lumbosacral sprain/strain and low back pain. Treatment of this patient's condition included cryotherapy, EMS and ultrasound.

Requested Services

Range of Motion, electrical stimulation unattended, HP physical therapy treatment, ultrasound, physical therapy re-evaluation from 6/14/04 through 8/11/04.

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

Documents Submitted by Requestor:

1. Position Paper 10/12/04
2. Review of Medical Records 8/5/04
3. Treatment Note 7/29/04 and 8/11/04

Documents Submitted by Respondent:

1. Review of Medical Records 8/5/04
2. MRI report 1/26/04
3. X-ray report 12/20/03
4. Evaluation and Treatment notes from 6/7/04 – 8/11/04

Decision

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

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a male patient who sustained a work related injury to his back on _____. The MAXIMUS chiropractor reviewer also noted that diagnoses for this patient included lumbosacral sprain/strain and low back pain. The MAXIMUS chiropractor reviewer indicated that the last treatment notes prior to 6/11/04 reported that the patient recovered. The MAXIMUS chiropractor reviewer also indicated that treatment notes from the period at issue in this appeal mention other injuries and body parts. The MAXIMUS chiropractor consultant explained that the length of this treatment was excessive for treatment of a low back condition. The MAXIMUS chiropractor consultant also explained that the treatment records from 6/11/04 do not document an aggravation of the member's low back condition. Therefore, the MAXIMUS chiropractor consultant concluded that the range of Motion, electrical stimulation unattended, HP physical therapy treatment, ultrasound, physical therapy re-evaluation services provided for this patient from 6/14/04 through 8/11/04 were not medically necessary for treatment of his condition.

Sincerely,
MAXIMUS

Lisa K. Maguire, Esq.
State Appeals Department