

MDR Tracking Number: M5-05-1298-01

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 01-04-05.

The IRO reviewed office visit, electrical stimulation, ultrasound, therapeutic exercises and whirlpool rendered from 06-08-04 through 07-14-04 that denied based upon "U".

The IRO determined that the office visit, electrical stimulation, ultrasound, therapeutic exercises and whirlpool from 06-08-04 through 06-21-04 **were** medically necessary. The IRO further determined that the electrical stimulation, ultrasound, therapeutic exercises and whirlpool from 06-23-04 through 07-14-04 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of 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 01-27-05, 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.

CPT code 97032 dates of service 05-10-04, 05-12-04, 05-14-04, 05-17-04, 05-19-04 and 05-21-04 (6 DOS) denied with denial code "N/205" (not documented/this charge was disallowed as additional information/definition is required to clarify service/supply rendered). The requestor submitted documentation to support delivery of service per Rule 133.307(g)(3)(A-F). Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$112.38 (\$14.98 X 125%= \$18.73 X 6 DOS)**.

CPT code 97022 dates of service 05-10-04, 05-12-04, 05-14-04, 05-17-04, 05-19-04 and 05-21-04 (6 DOS) denied with denial code "F/435" (fee schedule MAR reduction/the value of this procedure is included in the value of the comprehensive procedure). The carrier has made no payment. Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service code 97022 was comprehensive to. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$104.76 (\$13.97 X 125% = \$17.46 X 6 DOS)**.

CPT code 97018 dates of service 05-10-04, 05-12-04, 05-14-04, 05-17-04, 05-19-04 and 05-21-04 (6 DOS) denied with denial code "F/435" (fee schedule MAR reduction/the value of this procedure is included in the value of the comprehensive procedure). The carrier has made no payment. Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service code 97022 was comprehensive to. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$46.86 (\$6.25 X 125% = \$7.81 X 6 DOS)**.

CPT code 97035 dates of service 05-10-04, 05-12-04, 05-14-04, 05-17-04, 05-19-04 and 05-21-04 (6 DOS) denied with denial code "N/205" (not documented/this charge was disallowed as additional information/definition is required to clarify service/supply rendered). The requestor submitted documentation to support delivery of service per Rule 133.307(g)(3)(A-F). Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$88.86 (\$11.85 X 125%=\$14.81 X 6 DOS)**.

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 the amount of \$780.16 in accordance with the Medicare program reimbursement methodologies effective 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 is applicable for dates of service 05-10-04 through 06-21-04 in this dispute.

This Findings and Decision and Order are hereby issued this 24th day of March 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

March 10, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION Amended Determination 3/17/05

**RE: MDR Tracking #: M5-05-1298-01
TWCC #:
Injured Employee:
Requestor: La Plaza Rehab
Respondent: ARCFI
MAXIMUS Case #: TW05-0018**

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 female who sustained a work related injury on _____. The patient reported that while at work she injured her right arm/wrist when she pushed a cart through a door and the door struck her right arm and wrist. The initial diagnosis for this patient included right wrist sprain. The current diagnoses for this patient include hand injury NOS, acute median nerve compression, right wrist sprain, nervousness, muscle spasm and stiffness of joint. Treatment for this patient's condition has included physical therapy, carpal tunnel injection, neuromuscular stimulator, water circulating heater, and medications consisting of Tramadol, Celebrex, Cyclobenzapar, Flexeril, and Hydrocodone.

Requested Services

Office visit, electrical stimulation, ultrasound, therapeutic exercises, whirlpool from 6/8/04 through 7/14/04.

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

Documents Submitted by Requestor:

1. Weekly Therapy Summaries 5/31/04 – 7/12/04
2. MRI report 6/22/04
3. EMG report 7/6/04
4. Initial and Follow Up Examinations 5/19/04 – 7/16/04

Documents Submitted by Respondent:

1. Independent Review Organization Summary 2/1/05
2. Wrist and Forearm Exam report 4/5/04
3. MRI reports 6/22/04 and 11/24/04
4. Needle EMG report 7/6/04
5. Physical Performance Testing reports 5/26/04, 6/9/04, 6/23/04, 7/7/04, and 7/28/04
6. Office Notes 4/7/04 – 12/30/04

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 female who sustained a work related injury on _____. The MAXIMUS chiropractor reviewer indicated that the patient sustained a wrist injury that failed an initial treatment plan of conservative care. The MAXIMUS chiropractor reviewer noted that the patient changed treating doctors and began further treatment consisting of passive and active therapy. The MAXIMUS chiropractor reviewer indicated that there was no subjective or objective improvement documented with this additional care. The MAXIMUS chiropractor reviewer explained that 4-6 weeks of care for most musculo-skeletal conditions is medically appropriate care. The MAXIMUS chiropractor reviewer explained that the testing done every two weeks demonstrated that the patient was not making progress with the treatment rendered. The MAXIMUS chiropractor reviewer also explained that without the patient showing a positive response to treatment, there is no medical necessity for continued treatment. The MAXIMUS chiropractor reviewer further explained that 6 weeks of active and passive care is medically necessary and reasonable and that any treatment beyond that is not medically necessary.

Therefore, the MAXIMUS chiropractor consultant concluded that the office visit, electrical stimulation, ultrasound, therapeutic exercises, and whirlpool from 6/8/04 through 6/21/04 were medically necessary to treat this patient's condition. The MAXIMUS chiropractor consultant further concluded that the electrical stimulation, ultrasound, therapeutic exercises and whirlpool from 6/23/04 through 7/14/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department