

MDR Tracking Number: M5-05-1575-01

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. The dispute was received on 1-31-05.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

3 units of therapeutic exercises per visit, 1 unit of manual therapy per visit, office visits, and neuromuscular re-education from 3-31-04 through 7-16-04 **were found** to be medically necessary. More than 3 units of therapeutic exercises per visit and more than 1 unit of manual therapy per visit **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. The IRO reviewer found 3 units of therapeutic exercises per visit to be therapeutic. On most dates of service the insurance carrier has already reimbursed the requestor for 3 units of therapeutic exercises per visit. The amount due the requestor for the medical necessity issues is \$3,083.58.

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.

On 3-8-05 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.

Regarding CPT codes 99212, 97140, 97112 for 5-3-04 through 5-14-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's (tracking number from the delivery company) in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of the amount the requestor billed as follows:**

CPT code 99212 – \$227.05 (\$45.41 X 5 DOS).  
CPT code 97140 – \$339.00 (\$33.90 X 10 units).  
CPT code 97112 – \$183.45 (\$36.69 X 5 DOS).

Regarding CPT codes 97110 for 5-3-04 through 5-14-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's (tracking number from the delivery company) 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 99212 on 5-17-04, 5-19-04, 5-21-04, 5-26-04 and 5-28-04 was denied by the carrier as "G - This procedure is included in another procedure performed on the same date of service." Per Rule 133.304(c) and 134.202(a)(4) carrier didn't specify which service this was global to. Encoder Ingenix Pro verifies that there are no coding conflicts with the services billed on each day. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge. The requestor billed \$45.41, however the MAR is \$48.03. **Recommend reimbursement of \$227.05 (\$45.41 x 5 DOS).**

This Findings and Decision is hereby issued this 19th day of May 2005.

Medical Dispute Resolution Officer  
Medical Review Division

**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 \$4,060.13 from 3-31-04 through 7-16-04 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 Order is hereby issued this 19<sup>th</sup> day of May 2005.

Manager, Medical Necessity Team  
Medical Dispute Resolution  
Medical Review Division

Enclosure: IRO decision

April 15, 2005

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

**NOTICE OF INDEPENDENT REVIEW DECISION  
Amended Determination 4/21/05**

**RE: MDR Tracking #: M5-05-1575-01  
TWCC #:  
Injured Employee:  
Requestor: Pain & Recovery Clinic of North Houston  
Respondent: Gray Insurance Co/Flahive-Ogden & Latson  
MAXIMUS Case #: TW05-0050**

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 injured his right knee when he slipped in a puddle of diesel fuel and twisted his knee. The initial diagnoses for this patient included right knee pain and strain. Initial treatment for his condition included physical therapy and prescription medication. An MRI of the right knee performed on 12/2/03 indicated a complete versus high grade partial tear of the proximal anterior cruciate ligament, tear of the body of the medial meniscus, osteochondral lesion and/or contusion and/or fracture in the lateral femoral condyle, signal abnormality in the

popliteus muscle indicating strain and probable intrasubstance tearing, small effusion in the anterior compartment, and contusion within the tibial plateaus, most prominent in the lateral tibial plateau. The patient was treated with further conservative measures and subsequently was evaluated by an orthopedic surgeon. On 2/26/04 the patient underwent right knee arthroscopy, anterior cruciate ligament reconstruction, right knee, utilizing a free patellar tendon graft and a 8mm Kawasaki screw, and a bone graft (from the drillings) placed in the tibia and the patella. Postoperatively the patient was treated with a Bledsoe brace followed by postoperative physical therapy.

### Requested Services

Office visit, manual therapy, neuromuscular reeducation, and therapeutic exercises from 3/31/04 through 7/16/04.

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

#### *Documents Submitted by Requestor:*

1. Statement of Medical Necessity (no date)
2. MRI report 12/2/03
3. Operative Report 2/26/04
4. Physical Therapy Referral, Physical Therapy Evaluations, and Daily Progress Notes 3/30/04 – 8/11/04

#### *Documents Submitted by Respondent:*

None

### Decision

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

### Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted this case concerns a male who sustained a work related injury on \_\_\_\_\_. The MAXIMUS chiropractor reviewer indicated the patient had a serious knee injury with extensive surgical repair that required 6-9 months of therapy to return to working status. The MAXIMUS chiropractor reviewer explained the care was helpful in regaining strength and stability and moved him towards returning to work. The MAXIMUS chiropractor reviewer noted that 3 units of monitored therapeutic procedures were all that was required considering the additional forms of therapy given on each visit. The MAXIMUS chiropractor reviewer indicated joint mobilization was not indicated for a joint that was surgically repaired and where tightened myofascial release is indicated. The MAXIMUS chiropractor reviewer explained that office notes are needed to establish the progress and treatment for each day (99212). The MAXIMUS chiropractor reviewer neuromuscular re-education was also recommended to get the muscles and nerves working together to create a stable, fluid movement of the joint. (Official Disability Guidelines, TWCC Guidelines).

Therefore, the MAXIMUS chiropractor reviewer concluded that 3 units of therapeutic exercise (97110) per visit, 1 unit of manual therapy (97140) per visit, office visit (99212) and neuromuscular re-education (97112) from 3/31/04-7/16/04 were medically necessary treatment

for the patient's condition. The MAXIMUS chiropractor reviewer also concluded that the 4<sup>th</sup> unit of therapeutic and additional units of manual therapy for the period 3/31/04-7/16/04 was not medically necessary for treatment of the patient's condition.

Sincerely,  
**MAXIMUS**

Elizabeth McDonald  
State Appeals Department