

MDR Tracking Number: M5-05-1643-01

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 2-7-05.

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.

The office visits, manual therapy, neuromuscular education, therapeutic exercises, aquatic rehabilitation and electrical stimulation from 4-22-04 through 5-6-04 **were found** to be medically necessary. The office visits, manual therapy, neuromuscular education, therapeutic exercises, aquatic rehabilitation, electrical stimulation and collection and interpretation of physiologic data from 7-28-04 through 8-27-04 **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 issues is \$526.20.

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 2-25-05, 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.

CPT codes 99212, 97140- 97112 and 97113 on 4-27-04 and 4-29-04 were denied by the carrier as "O – previous recommendation will stand as they were defined." 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 carrier's EOB denials are unclear. Therefore, these services will be reviewed in accordance with the Medicare Fee Guidelines. Reimbursement is recommended as follows:

CPT code 99212 (2 DOS) - \$96.06  
CPT code 97140 (2 DOS) - \$67.82  
CPT code 97112 (2 DOS) - \$73.50  
CPT code 97113 (1 DOS) - \$42.20

CPT code 97110 on 4-27-04 and 4-29-04 was denied by the carrier as "O" – "previous recommendation will stand as they were defined." 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 99091 on 5-12-04 was denied by the carrier as "A - Preauthorization required, but not requested." Per Rule 134.600 this CPT code (Collection and interpretation of physiologic data, eg. ECG, blood pressure, glucose monitoring, digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time) does not require preauthorization. **Recommend reimbursement of \$108.00.**

**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 \$913.78 from 4-22-04 through 5-12-04 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 6<sup>th</sup> day of April 2005.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

DA/da

Enclosure: IRO decision

April 1, 2005

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

#### **NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-05-1643-01  
TWCC #:  
Injured Employee:  
Requestor: Complete Health and Rehab  
Respondent: Pacific Employees  
MAXIMUS Case #: TW05-0041**

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 low back when he slipped and fell from his truck. The initial impression for this patient included intervertebral disc injury lumbar spine, muscle spasm, lumbar radicular syndrome, and right inguinal hernia. The patient was initially treated with pain medications, muscle relaxants, therapeutic exercises, mechanical traction, electrical stimulation, ultrasound, and myofascial release. On 3/3/04 the patient underwent a lumbar decompressive laminectomy, bilateral foraminotomy, microscopic decompression of thecal sac and lateral stenosis for the preoperative diagnoses of lumbar stenosis with lateral recess stenosis and radiculopathy. Postoperatively the patient was treated with physical therapy consisting of neuromuscular reeducation, manual therapy, therapeutic exercises, and electrical stimulation, and medications.

#### Requested Services

99213/99212-office visits, 97140-man. therapy, 97112-neuromuscular education, 97110-therapeutic exercises, 97113-aquatic rehabilitation, 97032-electrical stimulation and 99091-collection and interpretation of physiologic data from 4/22/04 – 8/27/04.

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

##### *Documents Submitted by Requestor:*

1. Initial Medical Report 6/10/02
2. Chronic Pain Management Exam 7/27/04, 8/10/04

3. Operative Note 3/3/04
4. Follow Up Consultation Note 11/18/03 - 5/11/04
5. Daily Progress Notes 1/28/04 – 8/27/04

*Documents Submitted by Respondent:*

1. Daily Therapy Notes 1/22/03 – 2/4/04
2. Office Visit Notes 1/10/03 – 4/13/04
3. MRI Report 7/28/03

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 male who sustained a work related injury to his back on \_\_\_\_\_. The MAXIMUS chiropractor reviewer indicated that the patient has a degenerated spine. The MAXIMUS chiropractor reviewer also indicated that surgical intervention performed on 3/3/04 would help the radicular pain this patient was experiencing. The MAXIMUS chiropractor reviewer noted that the patient's low back pain was not improved with conservative measures and that surgical intervention would not have been beneficial. The MAXIMUS chiropractor reviewer noted that the patient had been treated with supervised therapy without experiencing relief. The MAXIMUS chiropractor reviewer also noted that the patient failed to demonstrate any objective or subjective improvement in his condition from 4/22/04 through 7/2004. The MAXIMUS chiropractor reviewer explained that the patient should have been transferred to a home based program at that time. The MAXIMUS chiropractor reviewer explained that the treatment this patient received did not cure his pain nor return him to work, therefore it did not meet the TWCC guidelines for continuation. The MAXIMUS chiropractor reviewer also explained that the patient's pain level never fluctuated more than 3 points during the time treatment was rendered, but that the treatment plan never changed. The MAXIMUS chiropractor reviewer indicated that 6 weeks of postoperative therapy was medically necessary to treat this patient's condition. Therefore, the MAXIMUS chiropractor consultant concluded that the 99213/99212-office visits, 97140-man. therapy, 97112-neuromuscular education, 97110-therapeutic exercises, and 97113-aquatic rehabilitation from 4/22/04 through 5/6/04 were medically necessary to treat this patient's condition. However, the MAXIMUS chiropractor consultant further concluded that the 99213/99212-office visits, 97140-man. therapy, 97112-neuromuscular education, 97110-therapeutic exercises, 97113-aquatic rehabilitation, 97032-electrical stimulation and 99091-collection and interpretation of physiologic data from 7/28/04 through 8/27/04 were not medically necessary to treat this patient's condition.

Sincerely,  
**MAXIMUS**

Elizabeth McDonald  
State Appeals Department