

MDR Tracking Number: M5-05-1654-01

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 2-8-05.

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 \$460.00** 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.

The ultrasound, office visits, electrical stimulation, therapeutic exercises, DME, neuromuscular reeducation, manual therapy technique, gait training, therapeutic procedures-group, and chiropractic manual treatment-spinal from 3-05-04 through 6-14-04 **were found** to be medically necessary. The ultrasound, office visits, electrical stimulation, therapeutic exercises, DME, neuromuscular reeducation, manual therapy technique, gait training, therapeutic procedures-group, and chiropractic manual treatment-spinal from 6-16-04 through 8-20-04 **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 \$4,403.98.

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 3-7-04 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.

HCPCS Code E1399 on 3-1-04 was denied by the carrier as "05 – the value of this procedure is included in the value of another procedure performed on this date. Per rule 133.304(c) and 134.202(a)(4) carrier didn't specify which service this was global to. **Recommend reimbursement per Rule 134.202(c)(1) of \$20.00.**

CPT codes 97032, 97035, on 3-1-04, 3-4-05 and 3-5-05, 3-8-04, 3-10-04 and 3-12-04 were denied by the carrier as "D 60 – The provider has billed for the exact services on a previous bill. Review of the claim file indicates these services have already been processed under Tax ID # 741830037 for this same provider." MDR made numerous attempts to contact the provider for verification. The provider did not respond. **Recommend no reimbursement.**

CPT code 99212 on 3-1-04, 3-4-05 and 3-8-04, 3-10-04 and 3-12-04 were denied by the carrier as “D 60 – The provider has billed for the exact services on a previous bill. Review of the claim file indicates these services have already been processed under Tax ID # 741830037 for this same provider.” MDR made numerous attempts to contact the provider for verification. The provider did not respond. Recommend no reimbursement.

CPT codes 97032 and 97035 on 3-29-04 were denied by the carrier as “YF-Reduced or denied in accordance with the appropriate fee guideline and D 60 – The provider has billed for the exact services on a previous bill. Review of the claim file indicates these services have already been processed under Tax ID # 741830037 for this same provider.” MDR made numerous attempts to contact the provider for verification. The provider did not respond. Recommend no reimbursement.

Regarding CPT code 97110 on 3-31-04 and 4-2-04 was denied as “01-the charge for the fee exceeds the amount indicated in the fee schedule” and on 8-11-04 and 8-13-04 (no EOB’s were provided): 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 97032 on 4-2-04 was denied as “01-the charge for the fee exceeds the amount indicated in the fee schedule”. The EOB reveals that this service was paid by the carrier; attempts to contact the requestor to verify this were unsuccessful. Recommend no reimbursement.

The carrier denied CPT Code 99080-73 on 6-4-04 with a U for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. A referral will be made to Compliance and Practices for this violation. Requestor submitted relevant information to support delivery of service. Recommend reimbursement of \$15.00.

The carrier denied CPT Code 99080-73 on 7-14-04 with a “TD – TD not properly completed or was submitted in excess of the filing requirements.” Requestor submitted relevant information to support delivery of service. Recommend reimbursement of \$15.00.

Neither the carrier nor the requestor provided EOB’s for CPT code 97116 (2 units) on 7-8-04. 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 \$63.12

Regarding CPT codes 97035, 97116, 99080-73, 99212, 99213, 97110, 97140, 99080, E1399 and 97032 on 8-11-04 and from dates of service 8-23-04 through 9-24-04: There is no "convincing evidence of the carrier's receipt of the request for reconsideration" according to 133.307 (g)(3)(A). No reimbursement recommended.

This Finding and Decision is hereby issued this 16th 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 \$4,517.10 from 3-5-04 through 7-18-04 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 16th day of May 2005.

Manager, Medical Necessity Team
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

April 22, 2005

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

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Determination 5/10/05**

**RE: MDR Tracking #: M5-05-1654-01
TWCC #:
Injured Employee:
Requestor: Pain & Recovery Clinic/Bose Consulting
Respondent: Texas Mutual Insurance Company
MAXIMUS Case #: TW05-0052**

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 fell from a stack of pipes injuring his back and left leg. An MRI of the left knee and performed on 3/10/04 revealed joint effusion of the left knee and a 6mm disc herniation at L4/5. An EMG performed on 5/6/04 revealed left L5 radiculopathy. The diagnoses for this patient have included knee sprain/strain, lumbar sprain/strain, lumbar radiculopathy, herniated nucleus pulposus, and low back pain. Treatment for this patient's condition has included epidural steroid injections received on 6/29/04 and 9/21/04, followed by active therapy.

Requested Services

OV-99212, ultrasound, electrical stimulation, therapeutic exercises, DME, neuromuscular reeducation, manual therapy technique, gait training, therapeutic procedures-group, chiropractic manual treatment-spinal, OV-99213, and OV-99211 from 3/5/04 through 8/20/04.

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

Documents Submitted by Requestor:

1. Position Statement (no date)
2. MRI reports 3/10/04
3. FCE reports 6/25/04, 9/28/04
4. Orthopedic report 7/21/04
5. Operative reports 9/21/04, 8/26/04, 6/29/04
6. Daily SOAP Notes 3/1/04 – 9/29/04

Documents Submitted by Respondent:

1. No documents 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 male who sustained a work related injury _____. The MAXIMUS chiropractor reviewer indicated that the patient sustained a sprain to his knee and a herniated disc on the right but has a left L5 radiculopathy. The MAXIMUS chiropractor reviewer noted that the patient had been treated conservatively for 4 months without demonstrating subjective or objective improvement. The MAXIMUS chiropractor reviewer also noted that the patient underwent 2 epidural steroid injections that offered a small amount of relief. The MAXIMUS chiropractor reviewer indicated that there is no sets of standard for length of conservative care following the epidural steroid injections to show that there was significant benefit in helping the patient recover compared to a home based program. The MAXIMUS chiropractor reviewer explained that the regimen of treatment did not change during the course of care. However, the MAXIMUS chiropractor reviewer also explained that this was medically necessary due to the complexity of the patient's injuries. The MAXIMUS chiropractor reviewer indicated that the lack of objective or subjective improvement after that period demonstrated that no further treatment was needed. The MAXIMUS chiropractor reviewer noted that both FCE's that this patient underwent demonstrated that the patient regressed instead of progressing. The MAXIMUS chiropractor reviewer explained that giving the patient an adequate trial of conservative care is medically necessary. However, the MAXIMUS chiropractor reviewer explained that the treatment this patient received did not relieve or cure his pain or enable him to return to work. Therefore, the MAXIMUS chiropractor consultant concluded that the office visits, ultrasound, electrical stimulation, therapeutic exercises, DME neuromuscular reeducation, manual therapy, gait training therapeutic procedures group and special manual treatment from 3/5/04 through 6/14/04 were medically necessary.

However, the MAXIMUS chiropractor consultant further concluded that the office visits, ultrasound, electrical stimulation, therapeutic exercises, DME, gait training, and chiropractic manual treatment-spinal from 6/16/04 through 8/20/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department