

MDR Tracking #M5-05-1883

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 2-16-05.

The IRO reviewed therapeutic activities and therapeutic exercises from 2-16-04 through 6-4-04 that were denied for medical necessity.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on 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 therapeutic activities and therapeutic exercises from 2-16-04 through 6-4-04 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. The MAR for Therapeutic Procedures is \$35.69 per unit. The requestor billed \$25.69 per unit. 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. Recommended reimbursement will be at \$25.69 per unit. **The amount due the requestor for the medical necessity issues is \$7,926.92.**

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 4-12-05 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.

On 2-16-04, 2-17-04, 2-18-04, 2-20-04, 2-23-04, 2-24-04, 2-25-04, 2-26-04, 2-27-04, 3-1-04, 3-3-04, 3-5-04, 3-8-04, 3-10-04, 3-12-04, 3-15-04, 3-17-04, 3-19-04, 3-22-04, 3-24-04, 3-26-04, 3-29-04, 3-31-04, 4-5-04, 4-7-04, 4-12-04, 4-16-04, 4-28-04, 4-30-04, 5-3-04, 5-5-04 and 5-7-04 the requestor billed CPT code 97140 on the same date of service as CPT code 98940 or CPT code 97530. The carrier denied these services as "G – Unbundling". Per Ingenix Encoder Pro CPT code 97140 is considered by Medicare to be a component procedure of CPT code 98940

and 97530. **Recommend no additional reimbursement on those dates where the carrier did reimburse or payment was ordered for CPT code 98940 or CPT code 97530.**

On 2-17-04, 2-18-04, 2-19-04, 2-20-04, 2-23-04, 2-24-04, 2-25-04, 2-26-04, 2-27-04, 3-1-04, 3-3-04, 3-5-04, 3-8-04, 3-10-04, 3-15-04, 3-17-04, 3-19-04, 3-22-04, 3-24-04, 3-26-04, 3-29-04, 3-31-04, 4-5-04, 4-7-04, 4-28-04, 4-30-04, 5-3-04, 5-5-04 and 5-7-04 the requestor billed CPT code 97112 on the same date of service as CPT code 98940. The carrier denied these services as “G – Unbundling”. Per Ingenix Encoder Pro CPT code 97112 is considered by Medicare to be a component procedure of CPT code 98940. **Recommend no additional reimbursement on those dates where the carrier did reimburse CPT code 98940.**

On 4-14-04, 4-23-04, 4-26-04, 4-30-04, 5-3-04, 5-7-04, 5-10-04, 5-12-04, 5-14-04, 5-19-04, 5-21-04, 5-24-04, 5-26-04, 5-28-04, 6-1-04, 6-2-04 and 6-4-04 the requestor billed CPT code 97116 on the same date of service as CPT code 97530. The carrier denied these services as “G – Unbundling”. Per Ingenix Encoder Pro CPT code 97116 is considered by Medicare to be a component procedure of CPT code 97530. **Recommend no additional reimbursement on those dates where reimbursement is recommended for CPT code 97530.**

CPT code 99070 was denied by the carrier as “F – Fee Guideline Mar Reducation.” In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of \$15.00.**

CPT code 99215 on 5-7-04 was denied as “G-Unbundling.” Per Rule 133.304(c) and 134.202(a)(4) carrier didn’t specify which service this was global to. Per Ingenix Encoder Pro this service is not bundled with any of the services performed on that date. **Recommend reimbursement per Rule 134.202(c)(1) of \$147.68.**

This Finding and Decision is hereby issued this 27th 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 \$8,089.60 for 2-16-04 through 6-4-04 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 27th day of May, 2005.

Manager, Medical Necessity Team
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

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HELPING GOVERNMENT SERVE THE PEOPLE®

May 24, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-1883-01
TWCC #:
Injured Employee: ____
Requestor: Dr. George Kris Wilson
Respondent: Insurance Company of the State of Pennsylvania
MAXIMUS Case #: TW05-0074

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, neck, and left knee after being hit by a car driven by his manager. Initial treatment for this patient consisted of medications and conservative care. An MRI performed on 2/19/02 revealed a 2-3mm annular bulge at the L4-5 level, a 3mm central focal soft tissue disc protrusion at the L5-S1, and a subtle tear within the posterior horn of the medial meniscus of the left knee intersecting the inferior articular surface of the meniscus near the meniscal apex. An EMG performed on 2/14/02 showed a C5 radiculopathy on the left/moderate to severe, and an L5 radiculopathy on the left/moderate to severe. On 4/1/02 the patient underwent a left knee partial meniscectomy and plica resection followed by postoperative rehabilitation. On 8/19/02 the patient underwent a L4 sacrum posterior fusion using titanium screw and plate system bilaterally and a L4 sacrum anterior lumbar interbody fusion with cages followed by postoperative therapy. On 11/16/03 the patient underwent removal of bilateral plate and screw system, fusion exploration, and repeat nonstrumented fusion from L4 through the sacrum using local decortication bone and Healos followed by postoperative rehabilitation beginning 2/16/04.

Requested Services

Therapeutic activities and therapeutic exercises from 2/16/04 – 6/4/04.

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

Documents Submitted by Requestor:

1. Treatment Summation 4/18/05
2. Treatment Summary 2/16/04 – 6/4/04
3. Operative Report 11/6/03
4. EMG/NCS Report 2/14/02
5. Discogram Report 7/3/02

Documents Submitted by Respondent:

1. No documents submitted

Decision

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

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his low back, neck and left knee on _____. The MAXIMUS chiropractor reviewer indicated that the injured worker underwent 2 fusion operations and required extensive

rehabilitation therapy because this procedure was performed twice. The MAXIMUS chiropractor reviewer noted that the treatment this patient received provided symptomatic and objective improvement. The MAXIMUS chiropractor reviewer also noted that the patient's neurological deficits were decreased, his lumbar spine range of motion was markedly improved, and his pain level was also decreased. The MAXIMUS chiropractor reviewer explained that the goals of the treatment rendered were met. Therefore, the MAXIMUS chiropractor consultant concluded that the therapeutic activities and therapeutic exercises from 2/16/04 – 6/4/04 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department