

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X) Yes (X) No
Requestor's Name and Address  J. C. M. L. R., P. A. P. O. Box 1660 San Antonio, TX 78296	MDR Tracking No.: M5-05-2588-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address  Texas Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY SERVICES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
6-2-04	6-8-04	CPT codes 97110 and 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

### PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if they are filed with the division no later than one year after the dates of service in dispute. The following dates of service are not eligible for this review: 7-11-03 through 5-6-04.

The Division has reviewed the enclosed IRO decision and determined that the requestor prevailed on the disputed medical necessity issues. 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 MAR for CPT code 97110 is \$34.46 and for CPT code 97140 is \$31.73. The total amount due the Requestor for the medical necessity services is \$540.44.

### PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services in dispute consistent with the applicable fee guidelines, totaling \$540.44, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna Auby

8-19-05

Authorized Signature

Typed Name

Date of Order

### PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_

**PART VI: YOUR RIGHT TO REQUEST A HEARING**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

August 17, 2005

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

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-05-2588-01**  
**TWCC #: \_\_\_\_**  
**Injured Employee: \_\_\_\_**  
**Requestor: J.C.M.L.R., P.A.**  
**Respondent: Texas Mutual Insurance Co.**  
**MAXIMUS Case #: TW05-0139**

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 physician on the MAXIMUS external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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 physician reviewer certified that the review was performed without bias for or against any party in this case.

#### Clinical History

This case concerns a 75 year-old female who sustained work related injuries on \_\_\_\_, including lumbosacral strain, cervical strain, tear of the rotator cuff on the left and a torn medial meniscus of the left knee. Treatment for the patient's condition has included physical therapy, rotator cuff repair in November 2003, and epidural steroid injections.

#### Requested Services

Therapeutic exercises – 97110 and manual therapy technique – 97140 from 6/2/04 to 6/8/04.

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

#### *Documents Submitted by Requestor:*

1. Letter regarding an independent medial evaluation dated 5/20/04
2. Initial Evaluation report dated 7/8/03 and follow-up records from 7/22/03 to 5/3/05
3. Lumbar spine evaluation reports dated 5/17/04, 2/9/05 and 6/1/05
4. Lower extremity evaluation reports dated 5/17/04, 7/14/04, 8/19/04, 9/22/04, 12/15/04, 3/16/05 and 5/11/05
5. Upper extremity evaluation dated 10/16/03, 11/20/03, 12/15/03, 2/12/04, 5/13/04, 10/6/04 and 1/12/05
6. Referral requests
7. Report a nerve conduction study/electromyogram performed on 2/24/04
8. Neurology records from 2/18/04

9. Report from a MRI of the lumbar spine performed on 2/15/05
10. Report from a MRI of the left knee performed on 2/7/04
11. Report from a MRI of the left shoulder performed on 10/9/03
12. Subjective re-evaluation reports dated 7/28/03, 8/8/03, 8/22/03, 9/23/03, 10/21/03, 11/25/03, 1/6/04, 2/13/04, 3/30/04, 4/27/04 and 5/4/05
13. Therapy and progress notes from 7/9/03 to 3/31/05
14. Patient travel cards from 2003, to 2005
15. Medical records dated 7/30/03, 7/16/03, 12/10/03, 1/7/04, 1/21/04, 2/25/04, 6/2/04, 6/30/04, and 9/1/04
16. Request for reconsideration dated 1/27/04

*Documents Submitted by Respondent:*

1. None submitted

**Decision**

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

**Rationale/Basis for Decision**

The MAXIMUS physician reviewer noted that this case concerns a 75 year-old female who sustained work related injuries on \_\_\_\_\_. The MAXIMUS physician reviewer also noted that the member's injuries included a lumbosacral strain, a cervical strain, a tear of her left rotator cuff and a left torn medial meniscus. The MAXIMUS physician reviewer indicated that this patient was receiving physical therapy for multiple injuries. The MAXIMUS physician reviewer also indicated that the patient's physical therapy included therapeutic exercises with pulleys for her left shoulder, and joint mobilization (manual therapy) for her left shoulder. The MAXIMUS physician reviewer explained that these physical therapy services were medically necessary for treatment of the member's shoulder injury.

Therefore, the MAXIMUS physician consultant concluded that Therapeutic exercises – 97110 and manual therapy technique – 97140 from 6/2/04 to 6/8/04 were medically necessary to treat this patient's condition.

Sincerely,  
**MAXIMUS**

Lisa K. Maguire, Esq.  
Project Manager, State Appeals