



Texas Department of Insurance, Division of Workers' Compensation  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### Retrospective Medical Necessity

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-0769-01
Horizon Health % Bose Consulting, L. L. C. P. O. Box 550496 Houston, Texas 77255	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
TX Mutual Insurance Company, Box 54	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "Necessary Treatment".

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Texas Mutual requests that the request for dispute resolution be conducted under the provisions of the APA set out above."

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
3-14-05 – 6-29-05	CPT code 97110 (\$35.86 X 90 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$3,227.40
3-14-05 – 6-29-05	CPT code 97112 (\$36.75 X 9 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$330.75
3-14-05 – 6-29-05	CPT code 97032 (\$20.34 X 3 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.02
3-14-05 – 6-29-05	CPT code 97140 (\$33.91 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$101.73
3-14-05 – 6-29-05	CPT code 97035 (\$15.53 X 3 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$46.59
3-14-05 – 6-29-05	CPT codes 99211, 97112, E0745	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

#### PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor did prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$3,767.49.

CPT code 99071 on 4-5-05 was denied by the carrier as "97-Payment is included in the allowance for another service/procedure." This code is a bundled service code and considered to be an integral part of a therapeutic procedure(s). Per the 2002 MFG, "This code is adjunct to basic services rendered. The physician reports this code to indicate educational supplies provided by the physician for the patient's education." Reimbursement for code 99071 is included in the reimbursement for the comprehensive therapeutic code. Additional payment cannot be recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1).

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to additional reimbursement in the amount of \$3,767.49. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision and Order by:

Donna Auby

1-27-06

Authorized Signature

Typed Name

Date of Order

**PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW**

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

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

January 25, 2006

Texas Department of Insurance Division of Texas Worker's Compensation  
MS48  
7551 Metro Center Drive, Suite 100  
Austin, Texas 78744-1609

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-06-0769-01**  
**DWC #:**  
**Requestor: Horizon Health**  
**Respondent: Texas Mutual Insurance Company**  
**MAXIMUS Case #: TW06-0005**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308, which allows for a dispute resolution by an IRO.

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 condition and treatment options at issue in this appeal. This case was also reviewed by a practicing physician on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. This physician is board certified in neurosurgery. The reviewers have met the requirements for the approved doctor list (ADL) of DWC or have been approved as an exception to the ADL requirement. A certification was signed that the reviewing providers have no known conflicts of interest between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO, was signed. In addition, the MAXIMUS physician reviewers certified that the review was performed without bias for or against any party in this case.

#### Clinical History

This case concerns an adult female who sustained a work related injury on \_\_\_\_\_. The patient reported that while working as a housekeeper, she slipped on a wet floor falling on her left side and back and hitting her knees. She complained of numbness of the left leg and left arm pain. Diagnoses included discogenic cervical and lumbar pain, L4/5 disc herniation and left knee tendonitis. Evaluation and treatment have included medications, physical therapy, MRIs, x-rays, nerve conduction velocity (NCV), injections and electromyographic (EMG) studies.

#### Requested Services

99211-OV, 97110-therapeutic exercises, 97112-neuromuscular reeducation, 97032-electrical stimulation, 97035-ultrasound, E0745-neuromuscular stimulator, 97140-manual therapy technique from 3/14/05-6/29/05.

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

*Documents Submitted by Requestor:*

1. Position Statement – not dated
2. Diagnostic Testing Reports (i.e., MRIs, EMG, etc) – 7/8/04, 10/26/04, 2/10/05
3. Regional Specialty Clinic Records –3/22/05-6/27/05
4. Operative Report – 4/7/05, 5/5/05

5. Horizon Health Records – 9/20/04-6/29/05

*Documents Submitted by Respondent:*

1. Diagnostic Records (e.g., MRIs, NCV, EMG, etc.) – 7/8/04, 8/26/04, 10/26/04, 2/10/05
2. Horizon Health Records – 9/20/04-7/13/05
3. Functional Capacity Evaluation – 10/19/04, 1/9/05
4. Orthopedic Records – 10/20/04, 5/13/05, 6/15/05
5. Designated Doctor Evaluation – 12/30/04, 6/22/05
6. Operative Report – 4/7/05, 5/5/05, 6/16/05
7. Regional Specialty Clinic Records – 4/18/05-8/11/05

**Decision**

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

**Standard of Review**

**This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.**

Rationale/Basis for Decision

The MAXIMUS chiropractor consultant indicated the member suffered injury to her cervical and lumbar spines and to her left knee. The MAXIMUS chiropractor consultant noted that a designated doctor had an opportunity to see this patient on 12/30/04 and it was his opinion that the patient was not yet at maximum medical independence (MMI) and that further therapy and possibly injections were necessary for treatment of her condition. The MAXIMUS chiropractor consultant also noted that when this designated doctor saw her again on 6/22/05, he found her to be at MMI with a 5% work behavior inventory (WBI). The MAXIMUS chiropractor consultant explained that another doctor who examined the patient on 5/13/05, opined in an addendum dated 6/15/05, "...I think it has been reasonable and appropriate" when specifically asked about the appropriateness of treatment duration and frequency to that point. The MAXIMUS chiropractor consultant indicated the medical records supplied by the treating chiropractor sufficiently fulfilled the statutory requirements because the patient obtained relief (the pain decreased), promotion of recovery was accomplished (range of motion improved) and there was an enhancement of the patient's ability to return to or retain employment. The MAXIMUS chiropractor consultant also indicated that for these reasons, the therapeutic exercises (97110), the electrical stimulation (97032), the ultrasound (97035), and the manual therapy techniques (97140) from 3/14/05-6/29/05 were supported as medically necessary.

The MAXIMUS chiropractor consultant noted that with respect to the neuromuscular reeducation services (97112), there was nothing in either the diagnostic or the physical examination findings that demonstrated the type of neuropathology that would necessitate application of this service. The MAXIMUS chiropractor consultant indicated neuromuscular reeducation therapy is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. The MAXIMUS chiropractor consultant noted that neuromuscular reeducation is reasonable and necessary for impairments that affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, and/or hypo/hypertonicity). The MAXIMUS chiropractor consultant also noted that the documentation in the medical records failed to clearly identify the need for this treatment.

The MAXIMUS chiropractor consultant explained in terms of the office visits (99211), there was no evidence in the medical records to support the medical necessity of an Evaluation and Management (E/M) service on each visit on a routine, day-to-day basis, particularly not during the performance of an already-determined treatment plan. (CPT Manual) The MAXIMUS chiropractor consultant indicated there was nothing in the medical records that discussed the neuromuscular stimulator (E0745) or provided adequate documentation concerning the medical rationale regarding the use or purpose of its dispensation. The MAXIMUS chiropractor consultant explained that for this reason, the neuromuscular stimulator device was not supported as medically necessary. (Texas Labor Code 408.021, HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B), CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised, American Medical Association, Chicago, IL 1999)

Therefore, the MAXIMUS chiropractor consultant concluded that the 97110-therapeutic exercises, 97112-nueromuscular reeducation, 97032-electrical stimulation, 97140-manual therapy technique and 97035-ultrasound from 3/14/05-6/29/05 were supported as medically necessary. The MAXIMUS chiropractor consultant also concluded that 99211-OV, 97112-neuromuscular reeducation and E0745-neuromuscular stimulator from 3/14/05-6/29/05 were not supported as medically necessary.

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department