

MDR Tracking Number: M5-04-0016-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 08-29-03.

The IRO reviewed therapeutic procedures and therapeutic activities rendered from 04-28-03 through 05-07-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for therapeutic procedures and therapeutic activities. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** 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 12-23-03, 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. Verified with requestor that payments were received for dates of service 04-21-03, 04-23-03, 04-28-03, 04-29-03, 99213 for 05-05-03, A4558 for 05-05-03, and 99213 for 05-06-03 and 05-07-03.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
04-14-03	99213	\$48.00	0.00	No EOB	\$48.00	MFG, E & M GR(IV)(C)(2)	Soap notes support delivery of service. Recommended Reimbursement \$48.00
	97110 (2 units)	\$70.00	0.00		\$35.00 per unit	MFG, MGR (I)(A)(9)(b)	See Rational below
	97530 (2 units)	\$70.00	0.00		\$35.00 per unit	MFG MGR (I)(11)(b)	Soap notes do not support delivery of service. Reimbursement is not recommended.
04-15-03	99213	\$48.00	0.00		\$48.00	MFG, E & M GR(IV)(C)(2)	Soap notes support delivery of service. Recommended Reimbursement \$48.00
	97110 (4 units)	\$140.00	0.00		\$35.00 per unit	MFG, MGR (I)(A)(9)(b)	See Rational below

	97530 (4 units)	\$140.00	0.00		\$35.00 per unit	MFG MGR (I)(11)(b)	Soap notes do not support delivery of service. Reimbursement is not recommended.
04-22-03	97750M T	\$43.00	0.00		\$43.00	MFG, MGR (I)(E)(3)	Soap notes do not support delivery of service. Reimbursement is not recommended.
	99213	\$48.00	0.00		\$48.00	MFG, E & M GR(IV)(C)(2)	Soap notes support delivery of service. Recommended Reimbursement \$48.00
	97110 (4 units)	\$140.00	0.00		\$35.00 per unit	MFG, MGR (I)(A)(9)(b)	See Rational below
	97530 (4 units)	\$140.00	0.00		\$35.00 per unit	MFG MGR (I)(11)(b)	Soap notes do not support delivery of service. Reimbursement is not recommended.
05-12-03	99213	\$48.00	0.00		\$48.00	MFG, E & M GR(IV)(C)(2)	Soap notes support delivery of service. Recommended Reimbursement \$48.00
	97110 (4 units)	\$140.00	0.00		\$35.00 per unit	MFG, MGR (I)(A)(9)(b)	See Rational below
	97530 (4 units)	\$140.00	0.00		\$35.00 per unit	MFG MGR (I)(11)(b)	Soap notes do not support delivery of service. Reimbursement is not recommended.
TOTAL		\$1215.00					The requestor is entitled to reimbursement of \$192.00

**RATIONAL**

Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings 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 per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(9)(b) 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. Additional reimbursement not recommended

**ORDER.**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Decision is applicable for office visits for dates of service 04-14-03 through 05-12-03 in this dispute.

This Decision is hereby issued this 22<sup>nd</sup> day of March 2004.

Georgina Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

November 21, 2003

**Re: IRO Case # M5-04-0016**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient injured her lower back in \_\_\_ when she lifted a tote box full of birdseed above her head to put into a dumpster. She has been treated with medication, lumbar ESIs, chiropractic treatment, physical therapy and therapeutic exercises. MRI evaluation was performed.

Requested Service(s)

Therapeutic procedure, therapeutic activities, 4/28/03-5/7/03

Decision

I agree with the carrier's decision to deny the requested treatment.

Rational

The patient received a fair trial of chiropractic treatment prior to the dates in dispute without documented objective relief of symptoms or improved function. The patient's pain scale was still 6-9 out of 10 after some three months of intensive chiropractic treatment and two lumbar ESIs.

The notes provided for this review are repetitive, having the same objective findings and subjective complaints with each visit. A diagnosed lumbar sprain/strain should resolve within 6-12 weeks, but the documentation provided showed little objective or subjective improvement.

A radiological report on 2/17/03 showed that there was evidence of early degenerative changes and ligamentous laxity in the lumbar spine. The MRI report of 2/17/03 revealed no neurological impingement and the patient's DTR's were routinely equal and reactive bilaterally. The

The therapeutic exercises and kinetic activities were unnecessary and unreasonable, being very basic in nature, and could have been done at home without supervision. The documentation provided failed to support the continued use of additional non-effective therapy that exceeded medically accepted guidelines for the severity of injury, intensity of service and appropriateness of care.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.