

MDR Tracking Number: M5-04-0189-01

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 09-15-03.

The IRO reviewed office visits (99213 and 99214), therapeutic exercises, neuromuscular re-education, rendered from 09-25-02 through 11-06-02 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 office visits (99213 and 99214), therapeutic exercises, neuromuscular re-education. 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 12-02-03, 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.

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
09-30-02	99213	\$73.00	0.00	N	\$48.00	MFG E&MGR (IV)(C)(2), MFG CPT Descriptor	Documentation submitted does not support level of service billed. Reimbursement is not recommended
	97110	\$200.00	0.00		\$175.00	MFG MGR (I)(A)(9)(b)	See Rational
	97112	\$40.00	0.00		\$35.00	MFG MGR (I)(A)(9)(b)	Documentation submitted does not support level of service billed. Reimbursement is not recommended
10-01-02	99213	\$73.00	0.00	N	\$48.00	MFG E&MGR (IV)(C)(2), MFG CPT Descriptor	Documentation submitted does not support level of service billed. Reimbursement is not recommended
	97110	\$280.00	0.00		\$245.00	MFG MGR (I)(A)(9)(b)	See Rational

	97112	\$40.00	0.00		\$35.00	MFG MGR (I)(A)(9)(b)	Documentation submitted does not support level of service billed. Reimbursement is not recommended
10-11-02	99213	\$73.00	0.00	N	\$48.00	MFG E&MGR (IV)(C)(2), MFG CPT Descriptor	Documentation submitted does not support level of service billed. Reimbursement is not recommended.
	97110	\$160.00	0.00		\$140.00	MFG MGR (I)(A)(9)(b)	See Rational
	97112	\$40.00	0.00		\$35.00	MFG MGR (I)(A)(9)(b)	Documentation submitted does not support level of service billed. Reimbursement is not recommended.
10-14-02	99213	\$73.00	0.00	N	\$48.00	MFG E&MGR (IV)(C)(2), MFG CPT Descriptor	Documentation submitted does not support level of service billed. Reimbursement is not recommended.
	97110	\$200.00	0.00		\$175.00	MFG MGR (I)(A)(9)(b)	See Rational
	97112	\$40.00	0.00		\$35.00	MFG MGR (I)(A)(9)(b)	Documentation submitted does not support level of service billed. Reimbursement is not recommended.
10-29-02	99213	\$73.00	0.00	N	\$48.00	MFG E&MGR (IV)(C)(2), MFG CPT Descriptor	Documentation submitted does not support level of service billed. Reimbursement is not recommended.
	97110	\$320.00	0.00		\$280.00	MFG MGR (I)(A)(9)(b)	See Rational
10-30-02	99214	\$112.00	0.00	N	\$71.00	MFG E&MGR (IV)(C)(2), MFG CPT Descriptor	Documentation submitted does not support level of service billed. Reimbursement is not recommended.
11-01-02	99213	\$73.00	0.00	N	\$48.00	MFG E&MGR (IV)(C)(2), MFG CPT Descriptor	Documentation submitted does not support level of service billed. Reimbursement is not recommended.
	97110	\$320.00	0.00		\$280.00	MFG MGR (I)(A)(9)(b)	See Rational
TOTAL		\$2190.00					The requestor is not entitled to reimbursement.

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 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-on-one therapy. Additional reimbursement not recommended

This Decision is hereby issued this 6th day of February 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

December 3, 2003

NOTICE OF INDEPENDENT REVIEW DECISION Corrected Letter

RE: MDR Tracking #: M5-04-0189-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ 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 ___ for independent review in accordance with this Rule.

___ 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 ___ 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. The ___ 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 ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 21 year-old female who sustained a work related injury on ___. The patient reported that while at work she was bending over to pick up an object when she experienced a "pop" in her lower back.

An MRI dated 6/18/02 showed central 3mm disc herniation at L3-L4 and L4-L5 with 50 percent stenosis of the left neural foramen at L4-L5 and a 2mm disc bulge at L5-S1. An EMG/NCV dated 7/16/02 showed evidence of left L5 nerve root irritation. Diagnoses for this patient include lumbar disc syndrome with myelopathy, myospasms, lumbosacral strain/sprain, and lumbar sprain/strain. The patient was initially treated with passive therapy that included ultrasound, MFR, interferential current, ice and traction. The patient was then treated with active therapy.

Requested Services

Office outpatient, therapeutic exercises, neuromuscular reeducation and establish E&M office visit from 9/25/02 through 11/6/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 21 year-old female who sustained a work related injury to her low back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient have included lumbar disc syndrome with myelopathy, myospasms, lumbosacral strain/sprain, and lumbar sprain/strain. The ___ chiropractor reviewer further noted that the patient has been treated with passive therapy that included ultrasound, MFR, interferential current, ice and traction followed by active therapy. The ___ chiropractor reviewer indicated that the treatment notes from 9/25/02 through 11/6/02 showed no objective or subjective improvement in this patient's pain or function. The ___ chiropractor reviewer explained that without relieving pain, restoring function or the ability to return to work, there is no medical necessity for ongoing care after three months. Therefore, the ___ chiropractor consultant concluded that the office outpatient, therapeutic exercises, neuromuscular reeducation and establish E&M office visit from 9/25/02 through 11/6/02 were not medically necessary to treat this patient's condition.

Sincerely,