

MDR Tracking Number: M5-04-0573-01

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 10-24-03.

The IRO reviewed office visits, office visits with e/m services, special reports, therapeutic exercises, myofascial release, hot or cold packs, electrical stimulation, and ultrasound rendered from 01-24-03 through 05-15-03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for office visits, office visits with e/m services, special reports, therapeutic exercises, myofascial release, hot or cold packs, electrical stimulation, and ultrasound. 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.

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 01-09-03, 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	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-18-02	E1399	\$495.00	0.00	Paid per EOB	DOP		Per EOB payment was rendered however requestor states payment was not received. Relevant information submitted does not meet DOP criteria reimbursement is not recommended.

12-30-02 01-06-03	99212	\$45.00	0.00	E	\$32.00	MFG, E & M GR (IV)(C)(2)	A review of the TWCC database reveals that a TWCC-21 was not filed with the Commission disputing compensability; therefore, this review will be based entirely upon the 1996 Medical Fee Guideline. Soap notes support delivery of service. Recommended Reimbursement \$64.00 (\$32.00 for 2 dates of service)
	99080-73	\$15.00	0.00	E	\$15.00		A review of the TWCC database reveals that a TWCC-21 was not filed with the Commission disputing compensability; Therefore, this review will be based entirely upon the 1996 Medical Fee Guideline. Work Status report was not submitted unable to confirm service rendered therefore, reimbursement is not recommended.
03-18-03 03-19-03 04-08-03 05-07-03	99211-25 (4 dates of service)	\$35.00 per date of service	0.00	E	\$18.00	MFG, E & M GR(IV)(C)(2)	A review of the TWCC database reveals that a TWCC-21 was not filed with the Commission disputing compensability; therefore, this review will be based entirely upon the 1996 Medical Fee Guideline. Soap notes support delivery of service. Recommended Reimbursement \$72.00 (\$18.00 for 4 dates of service)
03-18-03 04-08-03 04-09-03	97250 (3 dates of service)	\$45.00	0.00	E	\$43.00	MFG MGR (I)(C)(3)	A review of the TWCC database reveals that a TWCC-21 was not filed with the Commission disputing compensability; therefore, this review will be based entirely upon the 1996 Medical Fee Guideline. Soap notes support delivery of service. Recommended Reimbursement \$129.00 (\$43.00 for 3 dates of service)
03-18-03 03-19-03 03-20-03 04-08-03 04-09-03 05-07-03	97110 (4 units per date of service)	\$180.00 per date of service Total \$1080.00	0.00	E	\$35.00 per unit	1996 MFG, MGR (I)(A)(9)(b)	A review of the TWCC database reveals that a TWCC-21 was not filed with the Commission disputing compensability; therefore, this review will be based entirely upon the 1996 Medical Fee Guideline. See Rational Below

03-20-03 04-09-03	99212- 25	\$45.00 per date of service	0.00	E	\$32.00 per date of service	MFG, E & M GR(IV)(C)(2)	A review of the TWCC database reveals that a TWCC- 21 was not filed with the Commission disputing compensability; therefore, this review will be based entirely upon the 1996 Medical Fee Guideline. Soap notes support delivery of service. Recommended Reimbursement \$64.00 (\$32.00 for 2 dates of service)
04-09-03	97035	\$45.00	0.00	E	\$22.00	MFG MGR (I)(A)(9)(a)(iii)	A review of the TWCC database reveals that a TWCC- 21 was not filed with the Commission disputing compensability; therefore, this review will be based entirely upon the 1996 Medical Fee Guideline. Soap notes support delivery of service. Recommended Reimbursement \$22.00
TOTAL		\$2045.00					The requestor is entitled to reimbursement of \$355.00

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 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-to-one therapy. Additional reimbursement not recommended**

This Decision is hereby issued this 29<sup>th</sup> day of April 2004.

Georgina Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

**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 dates of service 12-30-02 through 05-15-03 in this dispute.

This Order is hereby issued this 29<sup>th</sup> day of April 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

January 2, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION  
Corrected Letter**

**RE: MDR Tracking #: M5-04-0573-01**

\_\_\_ 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 48 year-old male who sustained a work-related injury on \_\_\_. The patient reported that while at work he was carrying a heavy screen with two other workers when he tripped over an object on the floor and landed on his neck and upper back. The patient initially underwent X-Rays of the cervical and thoracic spine. The diagnoses for this patient have included post-traumatic hyperflexion injury to the cervical spine resulting in cervical radiculitis/radiculopathy, post-traumatic cervical facet-mediated pain with associated myospasm and biomechanical restriction and post-traumatic thoracic segmental dysfunction with associated myospasm. Treatment for this patient has included oral medications, a series of three epidural steroid injections followed by post-injection rehabilitation, EMS unit, ice pack and biofreeze, manual traction, ultrasound and hot/cold therapies.

### Requested Services

Office visits, office visits with e/m services, special reports, subsequent visits, exercises, myofascial release, hot or cold packs, electrical stimulation, ultrasound from 1/24/03 through 5/15/03.

### Decision

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

### Rationale/Basis for Decision

The \_\_\_ chiropractor reviewer noted that this case concerns a 48 year-old male who sustained a work related injury to his neck and upper back on \_\_\_. The \_\_\_ chiropractor reviewer also noted that the diagnoses for this patient have included post-traumatic hyperflexion injury to the cervical spine resulting in cervical radiculitis/radiculopathy, post- traumatic cervical facet-mediated pain with associated myospasm and biomechanical restriction and post-traumatic thoracic segmental dysfunction with associated myospasm. The \_\_\_ chiropractor reviewer indicated that the patient was receiving some benefit from the chiropractic care until he plateaued. The \_\_\_ chiropractor reviewer explained that the patient was referred for epidural steroid injections with post epidural steroid injection protocol and was found to have significant relief after each treatment. The \_\_\_ chiropractor reviewer indicated that the majority of care for this patient was the post epidural steroid injection therapy. The \_\_\_ chiropractor reviewer explained that this care is a recognized standard plan of care to facilitate faster healing. Therefore, the \_\_\_ chiropractor consultant concluded that the office visits, office visits with e/m services, special reports, subsequent visits, exercises, myofascial release, hot or cold packs, electrical stimulation, ultrasound from 1/24/03 through 5/15/03 were medically necessary to treat this patient's condition.

Sincerely,

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