

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: 453-05-4087.M5

MDR Tracking Number: M5-04-1222-01

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 1-2-04.

The IRO reviewed unattended electric stimulation, therapeutic exercises, therapeutic procedures, manipulation each additional area, hot/cold pack therapy, massage, conference with doctor, chiropractic manipulative treatment, office visits, office visits with manipulation, work release exam, telephone call by physician, prolonged evaluation rendered from 1-2-03 through 9-26-03 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. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 February 17, 2004, 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
1-10-03 3-13-03 5-16-03 6-16-03 7-18-03 7-22-03	99080-73	\$15.00	\$0.00	F	\$15.00	Rule 129.5(d)	Work status report indicates no change in claimant's work status – claimant remained off work; therefore, non-compliance with statute. No reimbursement is

8-13-03 9-10-03							recommended.
1-14-03 2-27-03 3-26-03 4-17-03 4-23-03 5-21-03 6-13-03 7-18-03	99199	\$90.00	\$0.00	N	DOP	General Instructions GR (III)	Unlisted special service or report. DOP requirements were not met per MFG. No reimbursement is recommended.
1-15-03 4-21-03 5-27-03 6-10-03 7-18-03	99358	\$30.00	\$0.00	F	\$84.00 or less	CPT Code Descriptor	MAR reimbursement of \$30.00 X 5 = \$150.00 is recommended.
3-3-03	97750(2)	\$200.00	\$0.00	D	\$100.00 /hr	Medicine GR (I)(E)(2)	Paid not in dispute.
2-28-03	95999	\$230.00	\$0.00	A	DOP	General Instructions GR (III) Rule 134.600	Rule 134.600(h)(8) states that, "unless otherwise specified, repeat individual diagnostic study, with a fee established in the current Medical Fee Guideline of greater than \$350 or documentation of procedure (DOP)." Unlisted neurological or neuromuscular diagnostic procedure -the requestor did not indicate that this was a repeat study that would require preauthorization, or if it was a repeat study that preauthorization was obtained.
3-13-03	99354	\$110.00	\$0.00	F	\$106.00	CPT Code Descriptor	MAR reimbursement of \$106.00 is recommended.
3-26-03 4-23-03 5-21-03 6-13-03	99214	\$150.00	\$0.00	N	\$71.00		Office visit reports support service billed per MFG, reimbursement of \$71.00 X 4 = \$284.00.
9-17-03	99214	\$150.00	\$0.00	N	\$103.24		Office visit reports support service billed per MFG, reimbursement of \$103.24 is recommended.
8-1-03	97110	\$50.00	\$0.00	F	\$35.00 / 15 min	Rule 134.202	See Rationale below.
9-17-03	99080	\$90.00	\$0.00	G	See Rule	Rule 133.106	A report is global to the office visit. A required narrative report is not global to an office visit. A report per Rule 133.106 was not submitted to support service; therefore, no reimbursement is recommended.
TOTAL							The requestor is entitled to reimbursement of \$643.24.

Rationale for 97110:

Recent review of disputes involving one-on-one CPT code 97110 by the Medical Dispute Resolution section 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 therapy notes for these dates of service do not support any clinical (mental or physical) reason as to why the patient could not have performed these exercises in a group setting, with supervision, as opposed to one-to-one therapy. The Requestor has failed to submit documentation to support reimbursement in accordance with Rule 134.202 and 133.307(g)(3). Therefore, reimbursement is not recommended.

DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for CPT codes, 99358, 99354, 99214 in the amount of **\$643.24**. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby **ORDERS** the Respondent to remit **\$643.24** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 21st day of December 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-04-1222-01
IRO Certificate Number: 5259

February 13, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical

information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Sincerely,

CLINICAL HISTORY

Patient received extensive physical medicine treatments after injuring his lower back on ___ after bending over to pick something up off the floor and felt a pop in his low back.

REQUESTED SERVICE(S)

Electrical stimulation-unattended, therapeutic exercises, therapeutic procedures, manipulation-each additional area, hot/cold pack therapy, massage therapy, conference with doctor, chiropractic manipulative treatment, office visits, office visits with manipulation, work release, exam, telephone call by physician and prolonged evaluation from 01/02/03 through 09/26/03.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

The time period from September 26, 2002 until January 1, 2003 gave the physician ample opportunity to render appropriate treatment that might have been beneficial for the patient's condition. Instead of improvement, the patient's symptoms remained essentially unchanged (4, 5, or 6 out of 10 on most every visit) during the entire treatment time. This lack of response documents that the referenced treatment did not cure or relieve the effects naturally resulting from the compensable injury, did not promote recovery and did not enhance the ability of the employee to return to work or retain employment. Therefore, the care was medically unnecessary under Texas Labor Code 408.021 (a).

This position is fully supported by TWCC Designated Dr. J, who after examining the patient, opined on March 24, 2003 that passive or standard physical therapy be discontinued and I completely concur with her opinion.

Although Dr. J did not address the issue of whether or not continued spinal manipulation might be beneficial, it is highly unlikely that additional low force treatment (“Activator” and “Sacro-Occipital Technique” [SOT] Blocking) would have yielded a different result. On the other hand, this reviewer is perplexed why a proper regimen of classic (thrust) spinal manipulation was not performed since according to the AHCPR¹ Guidelines, that type of spinal manipulation is the only treatment that can relieve symptoms, increase function and hasten recovery for adults with acute low back pain.

¹ Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.