

**TEXAS WORKERS' COMPENSATION COMMISSION**  
**MEDICAL REVIEW DIVISION, MS-48**  
**MEDICAL DISPUTE RESOLUTION**  
**FINDINGS AND DECISION**

MDR TRACKING#: M5-02-1245-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 1-7-04.

Date of service 1-6-03 was submitted untimely per Rule 133.308(e) and will not be considered further in this decision.

The IRO reviewed medical necessity of prolonged evaluation/management (99358), neuromuscular reeducation (97112), therapeutic activities (97530), unlisted special services/report (99199), unlisted eval/management service (99499), unusual travel (99082), unlisted modality (97039), and stimulation (unattended) (97014), office visits with manipulation (99213MP), therapeutic exercises (97110), team conference ((361), office visits (99213), non-emergency transport (A0100), hot/cold pack therapy (97010), electrical stimulation (97032), therapeutic procedures (97150), electrical stimulation (areas other than wound care) (G0283) between 1/7/03 through 11/06/03.

The IRO concluded that 99213MP, therapeutic activities (97530), and electrical stimulation (97014) for a maximum of three times per week until 2-18-03 **were found** to be medically necessary. All other services **were not** medically necessary.

On this basis, the total amount recommended for reimbursement (\$2552.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 4-22-04 the Medical Review Division submitted a Notice to the 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.

Neither party in the dispute submitted EOBs for some of the disputed services identified below. The requestor submitted convincing evidence that supports bills were submitted for audit. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline*.

CPT code 99213MP for the following dates of service were denied based upon “F” or “No EOB was submitted”: 1-7-03, 1-8-03, 1-10-03, 1-13-03 (2 units), 1-14-03, 1-15-03 (2 units), 1-16-03, 1-20-03 (2 units), 1-21-03, 1-22-03 (2 units), 1-23-03, 1-24-03 (2 units), 1-27-03 (2 units), 1-29-03, 1-30-03, 1-31-03 (2 units), 2-5-03 (2 units), 2-7-03, 2-10-03 (2 units were billed on this date IRO reviewed unit denied based upon “V”), 2-12-03 (2 units), 2-13-03, 2-14-03 (2 units), 2-17-03 (2 units), 2-19-03 (2 units), 2-20-03, 2-21-03 (2 units), 2-24-03 (2 units billed on this date, IRO reviewed 1 unit denied based upon “V”), 2-28-03 (2 units were billed on this date, IRO reviewed 1 unit denied based upon “V”), 3-3-02 (2 units), 3-4-03, 3-5-03 (2 units), 3-6-03, 3-7-03, 3-10-03 (2 units), 3-17-03, 3-18-03 (2 units), 3-19-03, 3-20-03, 3-21-03 (2 units), 3-24-03 (2 units on this date, IRO reviewed 1 unit denied based upon “V”), 3-26-03, 3-27-03, 3-28-03, 4-1-03, 4-2-03 (2 units), 4-3-03, 4-4-03 (3 units), 4-4-03, 4-8-03, 4-9-03 (2 units), 4-11-03 (2 units billed on this date, IRO reviewed 99213 denied based upon “V”), 4-14-03 (2 units billed on this date, IRO reviewed 99213 denied based upon “V”), 4-25-03 (2 units billed on this date, IRO reviewed 99213 denied based upon “V”), 4-28-03, 4-30-03 (2 units billed on this date, IRO reviewed 99213 denied based upon “V”), 5-20-03, 6-5-03, 7-18-03, 8-27-03 (2 units billed on this date, IRO reviewed 99213 denied based upon “V”), 9-12-03 (2 units billed on this date, IRO reviewed 99213 denied based upon “V”), 9-17-03 (2 units billed on this date, IRO reviewed 99213 denied based upon “V”), 10-3-03 (2 units billed on this date, IRO reviewed 99213 denied based upon “V”), and 11-10-03. A review of the TWCC-60 table indicates that requestor frequently billed for 2 or 3 office visits on the same date. 99213-MP is a physical medicine service. Medicine GR (I)(B)(1)(b), “When manipulations are administered by a doctor, other than a doctor of osteopathy, during an office visit, the office visit/manipulation shall be coded as follows: Established Patient Visit: the doctor shall use the code 99213 with the modifier “-MP.” A review of the SOAP notes indicate “Attending physician: Deanna Gray, P.T.” or “Attending physician: John S. Parker, D.C.” Medicine GR (I)(A)(8) states that, “Re-evaluation of the patient by the physical or occupational therapist is limited to code 99213. This re-evaluation shall be allowed no more than once every two weeks. DOP is required if this evaluation is performed more frequently.” Based upon the MFG, reimbursement for only one office visit will be allowed per date. On dates, where IRO reviewed 99213MP and recommended payment, the MDR did not recommend payment because one 99213MP was paid on that date. **Reimbursement of \$2466.19 is recommended. (50 dates x \$48.00 + 1 date x \$ 66.19)**

Regarding CPT code 99213 for dates of service 2-3-03 (also billed another unit on the same date that was denied by “V” and addressed by IRO), 2-6-03, 2-7-03 (billed other unit denied with “F” addressed above): this service was denied with a “G” – unbundling. As stated above, dates of service 2-3-03 and 2-7-03 were addressed by IRO and payment was already recommended. 99213MP is not global to physical therapy services rendered on this date; therefore, **reimbursement of \$48.00 is recommended for date of service 2-6-03.**

Regarding CPT code 99212MP for the following dates of service were denied based upon “F” or “No EOB was submitted”: 1-27-03, 2-3-03, 2-17-03, 2-24-03, 3-3-03, 3-24-03, 4-18-03 and 4-25-03. As stated above the requestor billed for more than one office visit on these dates, no reimbursement is recommended.

Regarding CPT code 99358 for the following dates of service were denied based upon “F” or “No EOB was submitted”: 1-8-03, 1-13-03, 1-20-03, 2-3-03, 2-20-03, 3-8-03, 4-4-03, 4-8-03: The disputed service will be reviewed according to the 1996 MFG. **Reimbursement of \$84.00 X 8 = \$672.00 is recommended.**

Regarding CPT code 99358 for date of service 3-21-03: this service was denied with a “G” – unbundling, A prolonged office visit is not global to any service billed on this date, reimbursement of **\$84.00** is recommended.

Regarding CPT code 97039-59 for the following dates of service were denied based upon “F” or “No EOB was submitted”: 1-8-03, 1-13-03, 1-15-03, 1-20-03, 1-22-03, 1-24-03, 1-27-03, 1-29-03, 3-28-03, 8-27-03, 9-5-03, 9-12-03, 9-17-03, 10-3-03, 11-10-03: The disputed service will be reviewed according to the 1996 MFG or the Medicare Fee Guidelines. Recommend reimbursement for the 9 dates X \$30.00= \$270.00 under the 1996 MFG. Reimbursement of \$90.60 is recommended for the 6 dates of service under the Medicare Fee Guidelines. (\$15.10 x 6). **TOTAL = \$360.60.**

Regarding CPT code 97014 for the following dates of service were denied based upon “F” or “No EOB was submitted”: 1-8-03, 1-13-03, 1-15-03, 1-20-03, 1-22-03, 1-24-03, 1-27-03, 1-29-03: The disputed service will be reviewed according to the 1996 MFG. **Reimbursement of \$15.00 X 8 = \$120.00 is recommended.**

Regarding HCPS code J3490 for the following dates of service were denied based upon “F” or “No EOB was submitted”: 1-27-03, 2-3-03, 2-17-03, 2-24-03, 3-3-03, 3-10-03, 4-4-03, 4-18-03, 4-25-03, 4-30-03. The requestor billed \$20.00 and was paid \$10.00. J3490 does not have a MAR. Rule 133.307(g)(3)(D) requires the requestor to submit documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement. The requestor failed to support amount billed was fair and reasonable and that additional reimbursement is due.

Regarding CPT code 99082 for dates of service 1-28-03 (2 units) and 2-10-03, “No EOB was submitted” to support denial of payment. Travel has been incorporated in the practice expense RVUs and is thus not separately payable. Separate payment for unusual travel is allowed only when the physician submits documentation to demonstrate that the travel was very unusual. Reimbursement is not recommended.

Regarding CPT code 99080-73 for date of service 2-3-03. There is no change in the claimant’s work status to support billing of report per Rule 129.5, no reimbursement is recommended.

Regarding CPT code 99361 for date of service 3-21-03, 4-11-03, 4-25-03. The requestor billed for 2 units, one was addressed by the IRO because it was denied with "V" and the other was denied with an F – Fee Guideline MAR reduction. Two team conferences were not performed on the same date. No reimbursement is recommended.

Regarding CPT code 99361 for dates of service 7-8-03. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.307 (f)(3). The disputed service will be reviewed according to the 1996 MFG. **Recommend reimbursement of \$53.00.**

Regarding CPT code 20550 for date of service 3-24-03. These services were denied with an F – Fee Guideline MAR reduction. The requestor billed \$40.00 and was paid \$20.00. 20550 has a MAR of \$40.00. The difference between amount paid and MAR = \$20.00. **Additional reimbursement of \$20.00 is recommended.**

Regarding CPT code 20550 for date of service 4-30-03 (2 units). Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.307 (f)(3). 20550 has a MAR of \$40.00. Per Surgery GR (I)(D)(2) the code is not exempt from the multiple procedure rule. Therefore,  $100\% = \$40.00 + 50\% = \$20.00 = \$60.00$ . **Reimbursement of \$60.00 is recommended.**

Regarding HCPS code A4550 for dates of service 3-24-03 and 4-30-03. These services were denied with an F – Fee Guideline MAR reduction. The requestor billed \$45.00 and was paid \$22.50. A4550 does not have a MAR. Rule 133.307(g)(3)(D) requires the requestor to submit documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement. The requestor failed to support amount billed was fair and reasonable and that additional reimbursement is due.

Regarding CPT code 97112 for dates of service 4-9-03 (1 unit), 4-25-03 (2 units), 5-20-03 (2 units), 6-5-03 (3 units), 7-18-03 (3 units): Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.307 (f)(3). The disputed service will be reviewed according to the 1996 MFG. 97112 has a MAR of \$35.00/15min.  $\$35.00 \times 11 \text{ units} = \$385.00$  **is recommended.**

Regarding CPT code 97110 for dates of service 4-25-03 (2 units), 6-5-03 (2 units), 7-18-03 (2 units): Recent review of disputes involving 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 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. Therefore, no reimbursement is recommended.

Regarding CPT code 99199 for dates of service 4-9-03, 4-25-03, 7-18-03: Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.307 (f)(3). The requestor billed \$25.00 and was paid \$0.00. 99199 does not have a MAR. Rule 133.307(g)(3)(D) requires the requestor to submit documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement. The requestor failed to support amount billed was fair and reasonable and that reimbursement is due.

Regarding CPT code 97010 for dates of service 8-27-03, 9-5-03, 9-12-03, 9-17-03, 10-3-03, 11-10-03. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's. The Trailblazer Local Coverage Determination (LCD) states that code 97010 "is a bundled code and considered an Integral part of a therapeutic procedure(s). Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment will not be made. Payment is included in the allowance for another therapy service/procedure performed.

Regarding CPT code G0283 for dates of service 8-27-03, 9-5-03, 9-12-03, 9-17-03, 10-3-03, 11-10-03. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.307 (f)(3). The disputed service will be reviewed according to the 1996 MFG or the Medicare Fee Guidelines.  $\$16.63 \times 6 =$  **\$99.78 is recommended.**

### **ORDER.**

Pursuant to 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) for dates of service through July 31, 2003; in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202(c); in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c)(6); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 1-7-03 through 11-10-03 as outlined above in this dispute.

This Decision is hereby issued this \_\_\_\_ day of \_\_\_\_\_, 2005.

Elizabeth Pickle  
Medical Dispute Resolution Officer  
Medical Review Division

**MEDICAL REVIEW OF TEXAS**  
**3402 Vanshire Drive**                      **Austin, Texas 78738**  
**Phone: 512-402-1400**                      **FAX: 512-402-1012**

**NOTICE OF INDEPENDENT REVIEW DETERMINATION**

**REVISED 11/16/04**

|  |                     |
|--|---------------------|
| TWCC Case Number:                                      |                     |
| MDR Tracking Number:                                   | M5-04-1245-01       |
| Name of Patient:                                       |                     |
| Name of URA/Payer:                                     | Parker Chiropractic |
| Name of Provider:<br>(ER, Hospital, or Other Facility) | Parker Chiropractic |
| Name of Physician:<br>(Treating or Requesting)         | John Parker, DC     |

April 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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: , Texas Workers Compensation Commission

#### CLINICAL HISTORY

Mr. \_\_\_\_\_, a 23-year-old male, sustained injuries to his lower back while working for Hernandez cable. He had been lifting heavy equipment when he developed an acute onset of lower back pain with left sided leg pain and numbness. He initially sought treatment from a chiropractor, Dr. Parker, who took the patient off work and instituted a conservative care régime consisting of manipulation with adjunctive physiotherapeutic modalities, multiple (mostly daily) times per week. The patient was medically co-managed by Dr. Small, a MD in the same group, who prescribed medication and treated the patient with trigger point injections. Behavioral psychotherapy services were included in October 2002. Diagnostically, the patient had an EMG/NCV on 10/15/02 which was abnormal, revealing **right**-sided S1 radiculopathy. MRI was performed on 10/28/02 with impression of L5/S1 disc disease/desiccation, and posterior disc protrusion with concave deformity of the thecal sac without neural compromise. Additional physical therapy was provided at the beginning of 2003, through Deanna Gray, PT. the patient continued on essentially a daily basis with multiple services rendered per date of service. A functional capacity evaluation was performed on 1/28/03 and showed the patient to be having continued postural and range of motion difficulties, although was able to lift in the Medium PDL category. Care continued again on an almost daily basis, with manipulation, along with two hours of therapeutic exercises/activities and neuro-muscular reeducation, in addition to electrical stimulation. A designated doctor evaluation by Armando Angel, M.D. in May of 2003 found him to not be at MMI. Orthopedic referral to Marvin Van Hal, M.D. recommended ESI's, a series of two were undertaken without much improvement. A discogram in August of 2003 was remarkable at the L5/S1 disc, and IDET was recommended, but not performed apparently. Spondylolysis was also identified at the L5 level around this time. Second neurosurgical opinions with Dr. Batlle, in October/November 2003 recommended surgical intervention consisting of anterior lumbar interbody fusion L5/S1 with posterior lumbar decompression and fusion with pedicle screw instrumentation. The patient continued with his physical therapy throughout this time frame.

### REQUESTED SERVICE(S)

Medical necessity of prolonged evaluation/management (99358), neuromuscular reeducation (97112), therapeutic activities (97530), unlisted special services/report (99199), unlisted eval/management service (99499), unusual travel (99082), unlisted modality (97039), and stimulation (unattended) (97014), office visits with manipulation (99213), therapeutic exercises (97110), team conference (99361), office visits (99213), non-emergency transport (A0100), hot/cold pack therapy (97010), electrical stimulation (97032), therapeutic procedures (97150), electrical stimulation (areas other than wound care) (G0283) between 1/07/03 -11/06/03.

### DECISION

There is establishment of medical necessity for manipulation (99213-MP), therapeutic activities (97530) and electrical stimulation (97014) for a maximum of three times per week until 02/18/03. No other services appear to be medically necessary. Any translation and transportation costs associated with the service dates approved above are also considered medically necessary.

### RATIONALE/BASIS FOR DECISION

*The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.*

The documentation from Dr. Parker fails to establish that the care provided satisfies any of the above three mandates of medical necessity. The records all appear to be of the computerized, "canned" variety. They are repetitious, contain minimally clinically useful information and do not show significant progress / substantive change in treatment. Unfortunately this provides precious little clinical insight as to the patient's status, his progression or improvement / response to care. There is also no clear or appropriate deviation to the treatment

April 13, 2004

Notice of Independent Review Determination

program with respect to the patient's lack of progression / response to treatment.

The patient underwent essentially three months of passive care without significant improvement. Active care consisting of therapeutic activities and "neuro-muscular re-education" was then attempted, and again no significant improvement is documented. The justification for essentially a daily régime of care continuing for several months post injury cannot be seen. According to the billing records, 30 hours of one-on-one exercise / active intervention was billed for January 2003 alone, injury in conjunction with other multiple services. Given that this patient may indeed have had a more significant injury than a "simple sprain/strain injury", a six-week course of active intervention at three times per week following a passive treatment trial should have been more than sufficient to realize any expectation of recovery or improvement. It really is abundantly clear from the documentation provided that conservative treatment interventions were ineffective and should have been discontinued by at least mid-February. This would be consistent with contemporary clinical guidelines that generally agree that if significant improvement is not noted with any therapy régime after four to six weeks, the patient should be re-assessed, treatment modalities altered and/or appropriate referral sought.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical probability and are totally independent of the requesting client.