

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, 133.307 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 01/26/04.

The IRO reviewed manual traction, myofascial release, office visit with manipulation, analysis of data stored in computer, manual therapeutic techniques, therapeutic exercises, orthotics, chiropractic manual treatment, joint mobilization, massage therapy, unlisted procedures and electrical stimulation rendered between 02/01/03 through 01/12/04 that were denied based upon "V" and "U".

Based on the IRO review, it was determined that the therapy rendered between 02/01/03 and 03/03/03 and the office visits dated 03/28/03, 04/28/03, 05/29/03, 06/26/03 and 07/31/03 were medically necessary. It was also determined that all remaining services rendered between 02/01/03 and 01/12/04 were not medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. 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 04/29/04, 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.

No EOB: Neither the Requestor nor the Carrier submitted EOBs for some of the disputed services identified below. Review will be in accordance with the *Medical Fee Guideline and TWCC Rules*.

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

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
03/26/03 through 1/06/04 (19 dos)	99080-73	\$15.00 each	\$-0-	V, No EOB	\$15.00	Rule 129.5(i); 133.106(f)(1)	The TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement of CPT code 99080-73 for 19 dates of service in the amount of \$285.00 (\$15.00 x 19).

4/30/03	99213- MP 97122 97265 97250	\$50.00 \$35.00 \$45.00 \$45.00	\$-0- \$-0- \$-0- \$-0-	D D D D	\$48.00 \$35.00 \$43.00 \$43.00	1996 Medical Fee Guideline	No original EOBs were submitted. The Carrier's reconsideration did not state a denial code other than "duplicate invoice". Recommend reimbursement of \$48.00 + \$35.00 + \$43.00 + \$43.00 = \$169.00 .
4/30/03 8/07/03 10/22/03	97110	\$35.00 each DOS	\$-0-	D	\$35.00	Same as above	See rationale below. No reimbursement recommended.
6/26/03	99213- MP 97122 97265 97250	\$50.00 \$35.00 \$45.00 \$45.00	\$-0-	No EOBs	\$48.00 \$35.00 \$43.00 \$43.00	133.304 (c); 133.307 (e)(2)(B)	The Requestor has not submitted convincing evidence of Carrier receipt of the provider request for an EOB. Reimbursement is not recommended.
8/07/03	98943	\$75.00	\$-0-	F	No Relative Value	134.202 (c)(6)	The Carrier denied reimbursement as "F – The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix." The Carrier did not assign a Relative Value Unit. Reimbursement is recommended.
8/07/03	97140- 59 (4 units)	\$180.00	\$-0-	F	\$26.04 x 125% each unit	134.202 (c)(1)	The Carrier denied reimbursement as "F – The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix." The Carrier has made no payment. Since the Carrier made no reimbursement, recommend reimbursement of \$130.20 (\$32.55 x 4 units).
8/07/03	G0283 as listed on table	\$20.00	\$-0-	EOB with no denial	\$15.81	134.202 (b)	The Requestor's HCFA billed using 97014. Requestor should have billed using G0283. Reimbursement not recommended.
10/22/03 11/12/03 11/18/03 12/02/03 12/30/03	98940	\$55.00 each DOS	\$-0-	No EOBs	\$31.68	133.304 (c); 133.307 (e)(2)(B)	The Requestor has not submitted convincing evidence of Carrier receipt of the provider request for an EOB. Reimbursement is not recommended.

10/22/03 11/12/03 12/02/03	97140	\$90.00 each DOS	\$-0-	No EOBs	\$65.10	133.304 (c); 133.307 (e)(2)(B)	The Requestor has not submitted convincing evidence of Carrier receipt of the provider request for an EOB. Reimbursement is not recommended.
11/18/03 12/17/03 12/30/03 1/06/04	97028	\$25.00 each DOS	\$-0-	No EOBs	\$7.21	133.304 (c); 133.307 (e)(2)(B)	The Requestor has not submitted convincing evidence of Carrier receipt of the provider request for an EOB. Reimbursement is not recommended.

11/22/03	99455-VR	\$50.00	\$-0-	No EOB	\$50.00	133.304 (c); 133.307 (e)(2)(B)	The Requestor has not submitted convincing evidence of Carrier receipt of the provider request for an EOB. Reimbursement is not recommended.
12/02/03 1/06/04	97139-EU	\$65.00 each DOS	\$-0-	No EOB	\$19.44	133.304 (c); 133.307 (e)(2)(B)	The Requestor has not submitted convincing evidence of Carrier receipt of the provider request for an EOB. Reimbursement is not recommended.
12/02/03 12/17/03 12/30/03 1/06/04	97124	\$30.00 each DOS	\$-0-	No EOB	\$27.14	133.304 (c); 133.307 (e)(2)(B)	The Requestor has not submitted convincing evidence of Carrier receipt of the provider request for an EOB. Reimbursement is not recommended.
12/17/03	99214	\$100.00	\$-0-	No EOB	\$78.48 x 125%	133.304(c); 133.307(e)(2)(B)	The Requestor has not submitted convincing evidence of Carrier receipt of the provider request for an EOB. Reimbursement is not recommended.
1/06/04	99455-V5-WP	\$600.00	\$-0-	No EOB	\$600.00	133.304 (c); 133.307 (e)(2)(B)	The Requestor has not submitted convincing evidence of Carrier receipt of the provider request for an EOB. Reimbursement is not recommended.
1/12/04	99090	\$110.00	\$-0-	No EOB	No Relative Value	133.304(c); 133.307(e)(2)(B)	The Requestor has not submitted convincing evidence of Carrier receipt of the provider request for an EOB. Reimbursement is not recommended.
1/14/03	S9982	\$240.00	\$-0-	No EOB	No Relative Value	133.304(c); 133.307(e)(2)(B)	The Requestor has not submitted convincing evidence of Carrier receipt of the provider request for an EOB. Reimbursement is not recommended.
TOTAL							Requestor is entitled to reimbursement in the amount of \$584.20.

RATIONALE:

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.

ORDER

- 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);

- 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 3/26/03 through 1/06/04 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 22nd day of November 2004.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division

PRD/prd

**NOTICE OF INDEPENDENT REVIEW DECISION
SECOND AMENDED DECISION**

Date: November 8, 2004

MDR Tracking #: M5-04-1477-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer who has an ADL certification. The reviewer has signed a certification statement stating 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 the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

According to the supplied documentation, it appears the claimant sustained an injury to her neck by performing repetitive rotation, which was reported to her employer on 05/31/2002. The claimant began chiropractic therapy that failed to produce adequate results. The claimant was referred to Dr. R. Dr. R initially performed trigger point injections and a left cervical block. Since

there was no positive improvement, Dr. R performed an anterior cervical microdiscectomy with anterior cervical fusion on 12/13/2002. The claimant underwent post-operative therapy. The claimant later completed a work hardening program and then a pain management program. Daily notes from 06/08/2002 – 07/23/2003 were submitted for review.

Requested Service(s)

Please review and address the medical necessity of the outpatient services including manual traction, myofascial release, office visit with manipulation, analysis of data stored in computer, manual therapeutic techniques, therapeutic exercises, chiropractic manual treatment, joint mobilization, massage therapy, unlisted procedures and electrical stimulation rendered between 02/01/2003 and 01/12/2004.

Decision

I agree with the treating doctor that the therapy rendered between 02/01/2003 – 03/03/2003 and the office visits dated 03/28/2003, 04/28/2003, 05/29/2003, 06/26/2003, and on 07/31/2003 were medically necessary. I agree with the insurance carrier that the remainder of treatments listed above are not medically necessary.

Rationale/Basis for Decision

According to the documentation supplied, the claimant initially underwent conservative therapy that failed. The claimant later underwent a surgical procedure to her cervical region. Following her operation, a period of healing time lasting from 6-8 weeks would have been necessary allowing only passive therapy. Following the healing period, active therapy would be deemed necessary. Since there appears to be some delayed healing of the fracture, then modified active therapy would be necessary. The claimant's treating doctor ordered plain film x-rays on 02/05/2003. Given that 2 weeks would be a reasonable timeframe for the films to be taken and reviewed, then an additional 2 weeks of modified therapy would be considered reasonable in the continuation of the claimant's care. Following this brief period of modified therapeutic activity period, then an appropriate transition to a home-based exercise program would be reasonable in the claimant treatment regimen. Doctor supervised therapy, either passive or active should have ceased on 03/03/2003. At this time the claimant would have had an extensive course of passive therapy and active therapy. The daily notes reviewed from Dr. V reported ongoing passive therapy, which is not objectively supported by the documentation or by current literature. Active therapy that was performed does not appear to be anymore beneficial than what could have been utilized in a home-based exercise program. The claimant could have been able to continue her therapy with an aggressive HEP that would have continued to benefit the claimant without inducing any potential doctor dependence. Overall, it appears that the claimant received an adequate trial of therapy prior to the surgery and after the surgery to help improve the claimant's symptoms. Monthly office visits appear reasonable to monitor the claimant's ongoing complaints and to referrals as necessary.