

MDR Tracking Number: M5-04-1550-01

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 1-30-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

The therapeutic exercises, manipulation, hot/cold packs therapy, massage therapy, and electrical stimulation treatments rendered from 6/9/03 through 7/21/03 **were found** to be medically necessary. The unlisted procedure, office visits, and all of the services rendered from 7/22/03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 May 18, 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.

- **CPT code 97261** for dates of service 6/9/03 and 7/07/03 was denied by the carrier with an "F"-fee guideline reduction code, however, no payment was rendered. Recommend reimbursement in the amount of \$24.00 for a total of 3 units.
- **CPT code 98941** for date of service 9/10/03 was denied by the carrier with a "G"-unbundling-and notes that this reimbursement for this procedure is included in the basic allowance for another procedure." However, the carrier did not state which billed procedure it was included under. Per Rule 133.304 (c), "at the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason for the insurance carrier's action. A generic statement that simply states a conclusion such as "not sufficiently documented"

or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section.” Therefore, **reimbursement is recommended** in the amount of \$41.89.

- **CPT code 97014** for date of service 6/9/03 was denied by the carrier with an “F”-fee guideline reduction code, however, no payment was rendered. Reimbursement is recommended in the amount of \$15.
- **CPT code 97110** on 8/13/03 was denied by the carrier with an “F”-fee guideline reduction code. 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. **Reimbursement is not recommended.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 Order is applicable to dates of service 6/09/03 through 9/10/03 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 4th day of October 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
RLC/rlc

NOTICE OF INDEPENDENT REVIEW DECISION

May 5, 2004

**Re: IRO Case # M5-04-1550
IRO Certificate #4599**

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of Disputed Services 2/28/03
2. Explanation of benefits
3. Neurosurgical follow up notes 10/7/02, 12/9/02, 2/17/03, 4/28/03, 6/4/03, 9/17/03
4. Report MRI lumbar spine 2/11/03
5. Report MRI right knee 2/22/02

6. D.C. office notes 1/2/03 –12/22/03
7. FCE 2/7/03

8. Operative report 5/22/03

History

The patient was injured in _____. He was treated by a chiropractor for pain in his low back and knees. He was rated at MMI on 12/9/96. The records provided for this review reflect continuing chiropractic and physical medicine treatment throughout 2003. It is unclear from the records if the patient suffered an exacerbation of pain or a re-injury, or if he had been continuously treated since 1996. The patient continues to have persistent low back and leg pain in 2003, and on 5/22/03 he underwent a microdiscectomy, hemilaminectomy, medial facetectomy and foraminotomy, MITR and HNP extirpation at L4-5.

Requested Service(s)

97110 ther exer, 97261 manipulation, 97010 hot/cold pack, 97124 mas ther, 97139 unlisted proc, 97213 99211 99212 ov, 97014 elec stim, 98941 98942 CMT 6/9/03 – 6/9/03

Decision

I disagree with the carrier's decision to deny codes 97110, 97261, 97010, 97124, 97014 6/9/03 – 7/21/03.

I agree with the decision to deny code 97131, office visits, and all services 7/22/03 forward.

Rationale

The patient had a remote injury to his low back, which apparently was either re-injured or exacerbated. Eventually he had surgery, including microdiscectomy. Physical therapy following surgery would be medically appropriate to improve range of motion, strength and activity tolerance. The records provided include no documentation to describe what code 97139 was, what its medical necessity was, or what its benefit was. An outpatient follow-up visit was billed and reimbursed on 7/8/03. Subsequent office visits were billed three times a week along with physical therapy sessions. There would be no medical necessity for such frequent follow ups. The patient was in an ongoing physical therapy program in which his condition was stable and slowly improving. A once a month follow up with his surgeon would be more reasonable. The patient had progressed in his physical therapy program by 7/21/03. On 7/21/03 it was documented that he reported 70% improvement. His pain level was 2/10 and his range of motion was rated as near normal. At this point he could have been discharged to a home exercise program.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.