

**MDR Tracking Number: M5-04-1578-01**

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. The dispute was received on 2-2-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. 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 \$650** 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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

The therapeutic exercises, office visits and ROM measurements from 3-11-03 through 7-24-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On 7-5-04, 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.

- One or more units of CPT Code 97110 – Therapeutic Procedures - were denied with F from 6-18-03 through 7-24-03. 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. **Additional reimbursement not recommended.**

- The carrier denied CPT Code 99080-73 on 8-13-03 with an F-The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requester submitted relevant information to support delivery of service. **Recommend reimbursement of CPT Code 99080-73 for a total of \$15.00.**

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 (b);
- 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 for date of service 3-11-03 through 8-13-03 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 1<sup>st</sup> day of October 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division  
DA/da

#### **NOTICE OF INDEPENDENT REVIEW DECISION**

June 7, 2004

**Re: IRO Case # M5-04-1578  
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 Neurological Surgery, 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 service 3/11/03 – 7/24/03
2. Explanation of benefits
3. Report CT /CT myelogram lumbar spine 4/14/03
4. Report EMG/NCS 2/18/03, 9/11/03
5. Report x-rays 1/3/03,8/18/03
6. Pain management M.D. notes
7. Neurosurgeon notes
8. Pain management treatment notes
9. Operative note ESI 3/10/03, 3/3/03, 10/29/03, 10/16/03
10. Orthopedic surgeon notes
11. Operative report 5/27/03
12. Treatment notes from treating D.C.

#### History

The patient is a 34-year-old male who in \_\_\_ was lifting a piece of stage equipment and developed low back pain. Despite physical therapy, epidural steroid injections, medications and manipulation, the patient continued to have pain, and CT

myelographic evaluation on 4/10/03 showed a significant L5-S1 disk rupture that was compatible with the patient's symptoms. On 5/27/03 lumbar laminectomy with discectomy was performed, but following this the patient was worse. The patient continues to have difficulty.

Requested Service(s)

Ther exer, OV, ROM measurements 3/11/03 –7/24/03

Decision

I disagree with the carrier's decision to deny the requested services.

Rationale

The requested treatment in March 2003 was reasonable in association with other conservative measures. There was no disputed treatment during the next two and one half months until after surgery. The treatment in June and July was in the fairly early post operative period. It is not unreasonable or unusual to pursue a rehabilitative exercise program, which may include ROM measures, when things are not going as well as one would like in the post operative period. The disputed measures were started approximately one month after surgery, which is not unusual. Although the rehabilitative measures were of no significant benefit, at the time they were ordered they were indicated as a possible means of improving the patient's status.

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