

MDR Tracking Number: M5-04-1744-01

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, 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 02-17-04.

The IRO reviewed office visits, radiological exam, joint mobilization, manual therapy technique, therapeutic activities and therapeutic exercises rendered from 03-13-03 through 10-17-03 that were denied based upon "U" and "V".

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 08-18-04, 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.

Review of CPT code 95900-27 (4 units) date of service 06-23-03 revealed that neither the requestor nor the respondent submitted an EOB. The requestor provided convincing evidence of carrier receipt of the providers request for an EOB in accordance with Rule 133.307(e)(2)(B). Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$256.00 (\$64.00 X 4 units).

Review of CPT code 95904-27 (2 units) date of service 06-23-03 revealed that neither the requestor nor the respondent submitted an EOB. The requestor provided convincing evidence of carrier receipt of the providers request for an EOB in accordance with Rule 133.307(e)(2)(B). Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$128.00 (\$64.00 X 2 units).

Review of CPT code 95925-27 (4 units) date of service 06-23-03 revealed that neither the requestor nor the respondent submitted an EOB. The requestor provided convincing evidence of carrier receipt

of the providers request for an EOB in accordance with Rule 133.307(e)(2)(B). Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$700.00 (\$175.00 X 4 units).

Review of CPT code 95935-27 (6 units) date of service 06-23-03 revealed that neither the requestor nor the respondent submitted an EOB. The requestor provided convincing evidence of carrier receipt of the provider's request for an EOB in accordance with Rule 133.307(e)(2)(B). Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$318.00 (\$53.00 X 6 units).

CPT code 99213 date of service 07-10-03 and dates of service 08-11-03 through 10-24-03 (34 dates total) denied with denial code "F" (fee guideline MAR reduction). The carrier has made no reimbursement. Reimbursement for date of service 07-10-03 is recommended per the 96 Medical Fee Guideline in the amount of \$48.00. Reimbursement for dates of service 08-11-03 through 10-24-03 is recommended in the amount of \$2,184.27 ($\$52.95 \times 125\% = \$66.19 \times 33 \text{ DOS}$) per the Medical Fee Guideline effective 08-01-03.

CPT code 97032 (18 units) dates of service 08-11-03 through 08-21-03 (9 DOS) denied with denial code "F" (fee guideline MAR reduction). The carrier has made no reimbursement. Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$375.30 ($\$16.68 \times 125\% = \$20.85 \times 18 \text{ units}$).

CPT code 97140 dates of service 08-11-03 through 10-24-03 (33 DOS) denied with denial code "F" (fee guideline MAR reduction). The carrier has made no reimbursement. Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$1,123.65 ($\$27.24 \times 125\% = \$34.05 \times 33 \text{ DOS}$).

CPT code 97530 (99 units) dates of service 08-11-03 through 10-24-03 (33 DOS) denied with denial code "F" (fee guideline MAR reduction). The carrier has made no reimbursement. Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$3,611.52 ($\$29.18 \times 125\% = \$36.48 \times 99 \text{ units}$).

CPT code 97110 dates of service 09-29-03 through 10-24-03 (9 DOS) denied with denial code "F" (fee guideline MAR reduction). 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. Reimbursement not recommended.

CPT code 97750-MT dates of service 04-02-03 through 07-14-03 (7 DOS) and 08-11-03 through 10-06-03 (5 DOS) denied with denial code "F" (fee guideline MAR reduction). The carrier has made no reimbursement. Reimbursement is recommended per the 96 Medical Fee Guideline for dates of service 04-02-03 through 07-14-03 in the amount of \$301.00 (\$43.00 X 7 DOS). Reimbursement for dates of service 08-11-03 through 10-06-03 is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$184.70 ($\$29.55 \times 125\% = \$36.94 \times 5 \text{ DOS}$).

CPT code 95851 dates of service 04-02-03 through 07-14-03 (7 DOS) denied with denial code "F" (fee guideline MAR reduction). The carrier has made no reimbursement. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$252.00 ($\$36.00 \times 7 \text{ DOS}$).

CPT code 95851 dates of service 08-11-03 through 10-06-03 (5 DOS) denied with denial code "G" (global). Per Rule 133.304(c) the carrier did not specify which service CPT code 95851 was global to. Reimbursement for dates of service 08-11-03 through 10-06-03 is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$178.90 ($\$28.62 \times 125\% = \$35.78 \times 5 \text{ DOS}$).

This Findings and Decision is hereby issued this 29th day of November 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 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) and in accordance with Medicare program reimbursement methodologies effective 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 Decision is applicable for dates of service 06-23-03 through 10-24-03 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 Order is hereby issued this 29th day of November 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

June 21, 2004

**Re: IRO Case # M5-04-1744 amended 11/17/04
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 a 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
2. Explanation of benefits
3. Letter to IRO from provider 3/26/04
4. Report of medical evaluation 3/5/04
5. Lumbar discographic reports 11/4/03, 12/6/02

6. Lumbar MRI report 5/28/02
7. Electrodiagnostic study results 6/23/03

8. Clinic visit reports 2003 –2004
9. Anterior Lumbar Interbody Fusion report 11/12/03
10. Procedure report intradiscal electrothermal coagulation 7/28/03
11. Multiple pain center reports 3/03 – 10/03

History

The patient is a 41-year-old female who on ___ developed back pain when she was lifting a pot full of materials. She was treated with physical therapy without benefit, and eventually was also treated with epidural steroid injections and intradiscal electrothermal coagulation without benefit. The patient underwent an extensive lumbar two-level fusion on 11/12/03 after the considerable physical therapy and other treatment measures were unsuccessful. The patient apparently continued to have significant pain in February 2002.

Requested Service(s)

OV, Radiol exam, joint mobil, elec stim, man ther tech, ther act, ther exer 3/31/03 – 10/17/03 denied with V and U codes

Decision

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

Rationale

Three to four weeks of therapy, including treatment and services such as that in this dispute may be of some benefit to patients. But after these measures were seen to be unsuccessful, their continuation was not indicated. In cases such as this, light mobilization to the lower lumbar spine, and manual mobilization to the upper lumbar spine do not facilitate healing in the injured patient's joints or provide pain relief, especially in a situation in which an eventual surgical procedure is to stabilize the joints.

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