

MDR Tracking Number: M5-04-1943-01

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 March 1, 2004.

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 \$460.00** 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.

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. The therapeutic exercises, subsequent visit, joint mobilization, myofascial release, manual traction, functional capacity evaluation rendered on 4/2/03 through 5/19/03 were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On June 2, 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.

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

DOS	CPT CODE	Billed	Paid	EOB Denial Code	Rationale
4/9/03	97110 x 5 units	\$175.00	\$140.00	O, YO	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 the one-on-one therapy and that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(9)(b) 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 is not recommended
5/8/03	97110 x 6 units	\$210.00	\$0.00		

4/8/03	95851	\$36.00	\$0.00	No EOB	Review of the requesters and respondents documentation revealed that neither party submitted copies of EOBs, however, review of the recon HCFA 1500s reflected proof of submission. Therefore, the disputed service or services will be reviewed according to the 1996 Medical Fee Guidelines. The requestor did not submit relevant information to support delivery of service. Reimbursement is not recommended.
5/8/03	99213	\$48.00	\$0.00	D, YO	Review of the carriers EOB dated 11/8/03 revealed the carrier denied CPT code 99213 as "D, YO-The provider has billed for the exact services on a previous bill. Reimbursement was reduced or denied after reconsideration of treatment / service billed." The requestor did not submit relevant information to support delivery of service.
TOTAL		\$469.00	\$140.00		The requestor is not entitled to reimbursement.

**ORDER**

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 4/2/03 through 5/19/03 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 8<sup>th</sup> day of October 2004.

Margaret Q. Ojeda  
 Medical Dispute Resolution Officer  
 Medical Review Division

MQO/mqo

May 12, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-04-1943-01**

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's

Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ----- external review panel and is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ----- chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a male who sustained a work related injury on -----. The patient reported that while at work he tripped over some plywood and lumber causing injury to his back. The diagnoses for this patient have included lumbar facet syndrome, lumbar segmental dysfunction, and muscle spasms. Initial treatment for this patient's condition has included injections, medicinal therapy, and rehabilitation. On 1/23/03 the patient presented for further treatment that consisted of exercises, joint mobilization, myofascial release, and manual traction. An MRI of the lumbar spine dated 2/6/03 indicated a normal MRI examination of the lumbar spine. The patient underwent an EMG/NCV on 4/24/03 that was reported to be normal.

### Requested Services

Exercises, subsequent visit, joint mobilization, myofascial release, manual traction, FC performance test from 4/2/03 through 5/19/03.

### Documents and/or information used by the reviewer to reach a decision:

#### *Documents Submitted by Requestor:*

1. Progress Notes 1/23/03 – 5/20/03
2. Consultation 1/23/03
3. MRI report 2/6/03
4. Orthopedic note 3/14/03
5. EMG/NCV 4/24/03
6. Initial Diagnostic Screening 5/21/03
7. Ergos evaluation summary report 5/19/03

#### *Documents Submitted by Respondent:*

1. No Documents Submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ----- physician reviewer noted that this case concerns a male who sustained a work related injury to his back on -----. The ----- chiropractor reviewer also noted that the diagnoses for this patient have included lumbar facet syndrome, lumbar segmental dysfunction, and muscle spasms. The ----- chiropractor reviewer indicated that this patient sustained a low back injury that was ultimately resolved, resulting in the patient returning to work with a 0% impairment rating and without restrictions. The ----- chiropractor reviewer explained that the patient had plateaued with care while reaching maximum medical improvement on 5/19/03. The ----- chiropractor reviewer also explained that the care this patient received was helpful in aiding in the recovery of this patient and followed the TWCC guidelines. The ----- chiropractor reviewer further explained that the functional capacity evaluation near the end of treatment is helpful to determine the patient's ultimate disposition for the injury. Therefore, the ----- chiropractor consultant concluded that the exercises, subsequent visit, joint mobilization, myofascial release, manual traction, FC performance test from 4/2/03 through 5/19/03 were medically necessary to treat this patient's condition.

Sincerely,

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