

MDR Tracking Number: M5-04-2051-01

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 March 5, 2004. Per Rule 133.308(e)(1) date of service 03/04/03 is outside the 365-day time frame and not within the jurisdiction of MDR; therefore this date of service will not be reviewed.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic exercises (97110), neuromuscular re-education (97112), therapeutic procedures (97150) and aquatic therapy (97113) for dates of service 03/24/03 through 03/28/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the 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 October 28, 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 19 days of the requestor's receipt of the Notice.

- CPT Code 97110 (50 units total) for dates of service 03/05/03 through 03/14/03 and 04/07/03 through 05/02/03. Neither party submitted EOBs; therefore, these dates of service will be reviewed in accordance with the TWCC Act, Rules and the 1996 Medical Fee Guideline. 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. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(9)(b) the requestor did not submit clinical notes to 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 97112 (10 units total) for dates of service 03/05/03 through 03/14/03 and 04/07/03 through 05/02/03. Neither party submitted EOBs; therefore, these dates of

service will be reviewed in accordance with the TWCC Act, Rules and the 1996 Medical Fee Guideline. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(10)(a) reimbursement in the amount of \$350.00 (\$35.00 x 10) is recommended.

- CPT Code 97150 (6 units total) for dates of service 03/05/03 through 03/14/03 and 04/07/03 through 05/02/03. Neither party submitted EOBs; therefore, these dates of service will be reviewed in accordance with the TWCC Act, Rules and the 1996 Medical Fee Guideline. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(10)(a) reimbursement in the amount of \$162.00 (\$27.00 x 6) is recommended.
- CPT Code 97113 (4 units total) for dates of service 03/06/03 and 04/08/03 through 05/01/03. Neither party submitted EOBs; therefore, these dates of service will be reviewed in accordance with the TWCC Act, Rules and the 1996 Medical Fee Guideline. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(10)(a) reimbursement in the amount of \$208.00 (\$52.00 x 4) is 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 of \$772.00 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 date of service 03/05/03 through 03/14/03 and 04/07/03 through 05/02/03 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 17th day of November 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO Decision

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NOTICE OF INDEPENDENT REVIEW DECISION

June 21, 2004

Re: IRO Case # M5-04-2051-01

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) 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, Rule 133.308 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 Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy 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 Orthopedic 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 Envoy 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 Envoy 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. Peer review, utilization review and recommendations 6/2/03, 5/22/03, 5/20/03
4. MRI right shoulder report 4/24/04
5. MRI of the lumbar spine report 1/8/03
6. X-ray report 5/7/02
7. MRI of the cervical spine report 6/15/02
8. Progress notes
9. Evaluation 4/1/04
10. Letter from physical therapist 12/11/03
11. Physical therapy records

History

The patient injured his right arm and neck when he was rear-ended in _____. He was diagnosed with a cervical and lumbar sprain. An MRI revealed multiple disk bulges and degenerative changes in the cervical and lumbar spine. The patient was treated with extensive physical therapy, including modalities, exercises and medications. According to the records provided, the patient has not had any injections or surgery. Physical therapy provided almost one year after the injury has been denied.

Requested Service(s)

97110 Ther exer, 97112 neuro reed, 97150 Ther proc, 97113 Aquatic ther 3/24/03 – 3/28/03

Decision

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

Rationale

The patient had underlying degenerative disk disease changes that were not related to the _____ injury. A diagnosis of cervical and lumbar strain usually involves 6-8 weeks of active and passive modalities and physical therapy. Physical therapy beyond 6-8 weeks has not been shown to be of any additional benefit over a home exercise program. Physical therapy beyond this point is not medically necessary or appropriate in cases such as this.

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

Daniel Y. Chin, for GP