

MDR Tracking Number: M5-04-2238-01

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 3-22-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of 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** 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.

The therapeutic exercises, neuromuscular reeducation, manual therapy technique, therapeutic activities, and level I office visit from 8-27-03 through 11-19-03 **were found** to be medically necessary. The therapeutic exercises, neuromuscular reeducation, manual therapy technique, therapeutic activities and level I office visit from 11-21-03 through 1-30-04 **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 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.

On 7-13-04 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.

CPT code 97110 for dates of service 9-10-03, 9-15-03, 9-19-03, 9-22-03, 9-24-03, 1-05-04, 1-16-04, 1-19-04, 1-30-04 and 2-04-04: 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.**

**Regarding all of the services listed below, the carrier either denied them as a "Duplicate" with the statement, "a reduction was made because a different provider has billed for the**

**exact services on a previous bill (however, no “sufficient explanation to allow the sender to understand the reason for the insurance carrier’s action” was provided to verify this statement) or no EOB at all was provided. According to 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(s) for the insurance carrier's action(s). 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, these dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, reimbursement is recommended for the following services:**

CPT code 97112 for dates of service 9-10-03, 9-15-03, 9-19-03, 9-22-03, 9-24-03, 1-05-04, 1-16-04, 1-19-04, 1-30-04 and 2-04-04: **reimbursement is recommended in the amount of \$367.20. (\$36.69 x 5 plus \$36.75 x 5)**

CPT code 97140 for dates of service 9-10-03, 9-15-03, 9-19-03, 9-24-03, 1-05-04, 1-16-04, 1-30-04 and 2-04-04: **reimbursement is recommended in the amount of \$271.28. (\$33.90 x 4 plus \$33.92 x 4)**

PT code 97530 for dates of service 9-10-03, 9-15-03, 9-19-03, 9-22-03, 9-24-03, 1-05-04, 1-16-04, 1-23-04, 1-26-03, 1-30-04 and 2-04-04: **reimbursement is recommended in the amount of \$404.41. (\$36.23 x 5 plus \$37.21 x 6)**

CPT code 99211 for dates of service 9-22-03, 9-24-03, 11-18-03, 11-26-03, 12-31-03, 1-05-04, 1-16-04, 1-23-04, 1-26-04, 1-30-04 and 2-04-04: **reimbursement is recommended in the amount of \$293.19. (26.19 x 5 plus \$27.04 x 6)**

This Findings and Decision is hereby issued this 18<sup>th</sup> day of November, 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

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 Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c) and 134.202(c)(6);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

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 18<sup>th</sup> day of November 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/da

June 9, 2004

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-04-2238-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent:**  
**----- Case #:**

----- 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 who 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 injured his head and neck. The patient has undergone MRI studies of the cervical spine, left hand, and lumbar spine on 7/3/03. On 7/28/03 the patient underwent an EMG/NCV study that was reported to have shown lumbar radiculopathy. The diagnoses for this patient have included lumbar spine disc protrusion, lumbar spine radiculopathy, and lumbar spine myofascial spasm. Treatment for this patient's condition has included physical therapy,

massage therapy, ultrasound and medications. The patient has also undergone lumbar epidural root blocks on 11/23/03, 1/9/04, and 2/20/04.

### Requested Services

Therapeutic exercises, neuromuscular reeducation, manual therapy technique, therapeutic activities, level I office visit from 8/27/03 through 1/30/04.

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

#### *Documents Submitted by Requestor:*

1. Designated Doctor Evaluation 11/11/03
2. Operative Reports 11/03 – 2/04
3. EMG report 7/28/03
4. MRI reports 7/3/03
5. Progress notes 8/27/03 – 2/4/04

#### *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 partially overturned.

### Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his head and neck on ----- . The ----- chiropractor reviewer also noted that the diagnoses for this patient have included lumbar spine disc protrusion, lumbar spine radiculopathy, and lumbar spine myofascial spasm. The ----- chiropractor reviewer indicated that this patient had significant positive findings with a congenital conjoined nerve root. The ----- chiropractor reviewer explained that this condition required a longer period of care before a referral for epidural steroid injections or other forms of care would be necessary. The ----- chiropractor reviewer noted that the patient showed no subjective or objective relief. The ----- chiropractor reviewer explained that after the epidural steroid injections were begun, there was no reason to continue the same type of care he had been receiving. The ----- chiropractor reviewer also explained that there is no documentation supporting follow up care after epidural steroid injections aids in the outcome subjectively. The ----- chiropractor reviewer further explained that the patient failed to show any improvement after the epidural steroid injections. Therefore, the ----- chiropractor consultant concluded that the therapeutic exercises, neuromuscular reeducation, manual therapy technique, therapeutic activities, level I office visit from 8/27/03 through 11/19/03 were medically necessary to treat this patient's condition. However, the ----- chiropractor consultant further concluded that the therapeutic exercises, neuromuscular reeducation, manual therapy technique, therapeutic activities, level I office visit from 11/21/03 through 1/30/04 were not medically necessary to treat this patient's condition.

Sincerely,