

MDR Tracking Number: M5-04-2480-01

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 4-9-4.

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.

The ROM, office visits, neuromuscular reeducation, therapeutic activities, therapeutic exercises, and manual muscle testing from 1-7-04 through 1-29-04 were 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 9-27-04 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.

**Regarding CPT Code 95851 for dates of service 11-4-03, 11-18-03 and 12-18-03: the carrier denied these services with "G". However, the carrier didn't specify which service these services were bundled to, therefore, according to Rule 134.202(a)(4) and Rule 133.304(c) they will be reviewed according Medicare Fee Schedule. Recommend reimbursement of \$214.68.**

**Regarding CPT Code 95833: Dates of service 11-5-03 and 1-06-04 were denied with a "G". No denial code was given for date of service 11-20-03 and the EOB stated that it was paid, however the requester states that it was not paid. Recommend reimbursement for all three dates of service since the carrier didn't specify which item these services were bundled to. According to Rule 134.202(a)(4) and Rule 133.304(c), they will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of \$156.42.**

Regarding CPT Code 99212 for dates of service 12-24-03 and 12-29-03: Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, the requester submitted HCFA's, EOB's, and proof of submission to the

carrier. Therefore, the disputed services will be reviewed according to the Medicare Fee Guidelines. **Recommend reimbursement of \$94.46.**

Regarding CPT Code 97140 for dates of service 12-24-03, 12-26-04, 12-29-03, 12-30-03: Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, the requester submitted HCFA's, EOB's, and proof of submission to the carrier. Therefore, the disputed services will be reviewed according to the Medicare Fee Guidelines. **Recommend reimbursement of \$136.20.**

Regarding CPT Code 97110 for dates of service 12-24-03, 12-26-03, 12-29-03 and 12-30-03: 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.**

Regarding CPT Code 97012 for dates of service 12-24-03, 12-26-04, 12-29-03 and 12-30-03: Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, the requester submitted HCFA's, EOB's, and proof of submission to the carrier. Therefore, the disputed services will be reviewed according to the Medicare Fee Guidelines. **Recommend reimbursement of \$68.60.**

Regarding CPT Code 99213 for dates of service 12-26-04 and 12-30-03: Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, the requester submitted HCFA's, EOB's, and proof of submission to the carrier. Therefore, the disputed services will be reviewed according to the Medicare Fee Guidelines. **Recommend reimbursement of \$132.38.**

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); 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 11-4-03 through 1-29-04 as outlined above 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 28<sup>th</sup> day of October, 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

June 18, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-04-2480-01**  
**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 56 year-old female who sustained a work related injury on ----- . The patient reported that while at work she was struck by some falling tools injuring her right leg and buttocks. The patient was initially treated with medications. The patient began chiropractic treatment in 11/03 with the treating chiropractor. A MRI of the lumbar and cervical spine was performed on 11/12/03. On 12/10/03 the patient underwent an EMG/NCV. A myelogram with CT scan following performed on 12/3/03 indicated generalized disc bulge/facet hypertrophy at L4-5, generalized disc bulge at L5-S1/facet hypertrophy, generalized disc bulge at L3-4/facet hypertrophy, and generalized disc bulge L2-3. Treatment for this patient's condition has included chiropractic treatment, neuro-reeducation, therapeutic exercises, and therapeutic activities.

### Requested Services

ROM, office visits, neuro reeducation, therapeutic activities, therapeutic exercises, and manual muscle testing from 1/7/04 through 1/29/04.

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

*Documents Submitted by Requestor:*

1. Designated Doctor Evaluation 4/20/04
2. MRI report 11/12/03
3. EMG/NCV report 12/10/03
4. Myelogram/CT scan report 12/3/03
5. Office notes 11/3/03 – 3/9/04

*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 overturned.

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a 56 year-old female who sustained a work related injury to her right leg and buttocks on -----. The ----- chiropractor reviewer also noted that the treatment for this patient's condition has included chiropractic treatment, neuro-reeducation, therapeutic exercises, and therapeutic activities. The ----- chiropractor reviewer indicated that this patient had multiple areas of involvement that had positive objective and subjective findings. The ----- chiropractor reviewer explained that 6-8 weeks of treatment with therapy for one area is medically necessary treatment. However, the --- --- chiropractor reviewer also explained that with multiple areas involved, 10-12 weeks of treatment with therapy would be medically necessary. The ----- chiropractor reviewer noted that the patient was not deemed to be at maximum medical improvement until 4/04. The ----- chiropractor reviewer explained that although the treatment rendered to this patient was only mildly affective, it was still medically necessary. Therefore, the ----- chiropractor consultant concluded that the range of motion, office visits, neuro reeducation, therapeutic activities, therapeutic exercises, and manual muscle testing from 1/7/04 through 1/29/04 were medically necessary to treat this patient's condition.

Sincerely,

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