

MDR Tracking Number: M5-04-2708-01

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. This dispute was received on 4-26-04.

The IRO reviewed ROM Measurements, office visit, manual therapy technique, therapeutic exercises, mechanical traction ,therapeutic activities, muscle testing, neuromuscular re-education rendered from 12-22-03 through 2-25-04 that were denied based upon "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.

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

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services identified below. The requestor submitted a copy of a signed certified green card that supports bills were submitted for audit. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-9-03	97110 (4)	\$136.20	\$0.00	F	\$136.20	CPT Code MAR	See Rationale below, no reimbursement is recommended.
12-23-03 1-8-04	99213	\$66.19	\$0.00	No EOB	\$66.19	CPT Code MAR	MAR reimbursement of \$66.19 X 2 = \$132.28 is recommended.
12-29-03 1-13-04	99212	\$47.23	\$0.00	No EOB	\$47.23	CPT Code MAR	MAR reimbursement of \$47.23 x 2 dates = \$94.46 is recommended.
12-29-03 1-8-04	97530 (4)	\$145.92	\$0.00	No EOB	\$145.92	CPT Code MAR	MAR reimbursement of \$145.92 X 3 dates = \$437.76 is recommended.

1-13-04							
1-8-04	E0745	\$111.34	\$0.00	No EOB	F&R	CPT Code MAR	Requestor did not dispute amount billed was not fair and reasonable; therefore, reimbursement of \$111.34 is recommended.
1-8-04	95851	\$71.56	\$0.00	No EOB	\$71.56	CPT Code MAR	MAR reimbursement of \$71.56 is recommended.
1-19-04	97112	\$36.94	\$0.00	No EOB	\$36.94	CPT Code MAR	MAR reimbursement of \$36.94 is recommended.
1-19-04	97112	\$36.94	\$0.00	No EOB	\$36.94	CPT Code MAR	MAR reimbursement of \$36.94 is recommended.
1-19-04	99212	\$48.99	\$0.00	No EOB	\$48.99	CPT Code MAR	MAR reimbursement of \$48.99 is recommended.
2-9-04	99211	\$27.86	\$0.00	N	\$27.86	CPT Code Descriptor	Report to challenge carrier's position was not submitted per Rule 133.307(g)(3)(B); therefore, no reimbursement is recommended.
TOTAL							The requestor is entitled to reimbursement of \$970.27 .

Rationale for 97110:

Recent review of disputes involving one-on-one 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 therapy notes for these dates of service do not support any clinical (mental or physical) reason as to why the patient could not have performed these exercises in a group setting, with supervision, as opposed to one-to-one therapy. The Requestor has failed to submit documentation to support reimbursement in accordance with the Rule 134.202 and 133.307(g)(3). Therefore, reimbursement is not recommended.

DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for CPT codes, 99211, 99212, 99213, 97112, 97530, 95851, E0745, in the amount of **\$920.27**. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **\$920.27** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 10th day of November 2004.

Elizabeth Pickle
 Medical Dispute Resolution Officer
 Medical Review Division

July 15, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2708-01
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 42 year-old female who sustained a work related injury on ----- . The patient reported that while at work she injured her neck, left shoulder and upper back areas. A MRI of the right shoulder and thoracic spine performed on 12/15/03 revealed mild arthrosis of the right acromioclavicular joint and a 2.0 x 1.5 cm paralabral cyst in the spinoglenoid notch of the right shoulder, and mild disc spondylosis of each from T3-T4 through T7-T8 including a small left paracentral to left lateral disc protrusion at T6-T7. The diagnoses for this patient have included intervertebral cervical disc d/o with myelopathy cervical region, totator cuff syndrome shoulder and allied disorders, and thoracic sprain and strain. Treatment for this patient's condition has included massage therapy, therapeutic exercises and activities, and mechanical traction.

Requested Services

Range of motion measurements, office visit, manual therapy technique, therapeutic exercises, mechanical traction, therapeutic activities, muscle testing and neuromuscular reeducation from 12/22/03 through 2/25/04.

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

Documents Submitted by Requestor:

1. MRI reports of right shoulder and thoracic spine 12/15/03
2. Required medical examination 1/20/04
3. Ortho Notes 1/26/04 – 2/4/04
4. SOAP notes 12/9/03 – 1/26/04

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 upheld.

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a 43 year-old female who sustained a work related injury on -----. The ----- chiropractor reviewer indicated that the diagnoses for this patient have included rotator shoulder cuff syndrome and allied disorders, intervertebral disc disorder with myelopathy, cervical region and sprain/strain thoracic region. The ----- chiropractor reviewer noted that the treatment for this patient's condition has included various exercises, manual therapies and mechanical traction approximately three times a week. The ----- chiropractor reviewer explained that this patient had been under chiropractic care for approximately three and one-half months. The ----- chiropractor reviewer indicated that throughout the course of treatment this patient reported the same complaints of neck pain, upper back pain and shoulder pain. The ----- chiropractor reviewer noted that there was no evidence in change of subjective complaints throughout care. The ----- chiropractor reviewer also indicated that objectively throughout care the patient experienced fixations, palpation findings, joint restrictions, muscle restrictions and muscle spasms. The ----- chiropractor reviewer explained that the documented findings do not support long-term ongoing care. The --- --- chiropractor reviewer indicated that although the patient had been diagnosed with a partial tear, minimal arthritic and disc findings, the patient's examinations, chart notes and diagnoses do not substantiate the need for extended care. The ----- chiropractor reviewer explained that without evidence of objective improvement and a decrease in modalities employed, the patient had exceeded a reasonable prognosis for care. The ----- chiropractor reviewer also explained that this patient had not responded to treatment rendered. Therefore, the ----- chiropractor consultant concluded that the range of motion measurements, office visit, manual therapy technique, therapeutic exercises, mechanical traction, therapeutic activities, muscle testing and neuromuscular reeducation from 12/22/03 through 2/25/04 were not medically necessary to treat this patient's condition.

Sincerely,