

MDR Tracking Number: M5-04-2807-01

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 04-30-04.

The IRO reviewed range of motion measurements, therapeutic exercises, muscle test, manual therapy, KO elastic with joints, mechanical traction rendered from 01-19-04 through 02-12-04 that were denied based upon "U".

The IRO determined that code 95851 date of service 01-19-04 and code 97110 dates of service 01-19-04, 01-21-04, 01-26-04, 01-28-04, 02-02-04, 02-05-04, 02-09-04, 02-11-04 and 02-12-04 as well as code 95833 date of service 02-05-04 **were** medically necessary. The IRO determined that code 97012 and 97140 for all dates of service in dispute, code 95833 date of service 01-21-04, code L1810 date of service 02-09-04, and code 97110 date of service 01-22-04 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of 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. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-30-04, 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.

Review of the requestor's and respondent's documentation revealed that neither party submitted a copy of the EOB for CPT code **99213** date of service 01-29-04. Review of the reconsideration HCFA and submission of a copy of a certified mail receipt by the requestor reflected proof of submission to the carrier per Rule 133.308(f)(2)(3). The service is reviewed per the Medical Fee

Guideline effective 08-01-03. Reimbursement in the amount of **\$68.24** (\$54.59 X 125%) is recommended.

Review of the requestor's and respondent's documentation revealed that neither party submitted a copy of the EOB for CPT code **97140** date of service 01-29-04. Review of the reconsideration HCFA and submission of a copy of a certified mail receipt by the requestor reflected proof of submission to the carrier per Rule 133.308(f)(2)(3). The service is reviewed per the Medical Fee Guideline effective 08-01-03. Reimbursement in the amount of **\$34.13** (\$27.30 X 125%) is recommended.

Review of the requestor's and respondent's documentation revealed that neither party submitted a copy of the EOB for CPT code **97110** dates of service 01-29-04 and 02-04-04. No reimbursement is recommended. See rationale below.

CPT code **99213** dates of service 01-21-04, 02-12-04, 02-19-04, 02-23-04 and 02-25-04 denied with code "MU" (physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code on the same date of service). The Trailblazer Local Coverage Determination (LCD) states in part, "When both a modality/procedure and an evaluation is clearly documented. Standard medical practice may be one or two visits in addition to physical therapy therapy treatments. Reimbursement beyond this standard utilization requires documentation supporting the medical necessity for the office visit". The LCD does not prohibit the billing of office visits with evaluation and management codes and the office visits on these dates of service were not denied for medical necessity. Per the Medical Fee Guideline effective 08-01-03 reimbursement in the amount of **\$341.20** (\$54.59 X 125% = \$68.24 X 5 DOS) is recommended.

CPT code **99212** dates of service 01-26-04, 02-11-04 and 02-18-04 denied with code "MU" (physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code on the same date of service). The Trailblazer Local Coverage Determination (LCD) states in part, "When both a modality/procedure and an evaluation is clearly documented. Standard medical practice may be one or two visits in addition to physical therapy therapy treatments. Reimbursement beyond this standard utilization requires documentation supporting the medical necessity for the office visit". The LCD does not prohibit the billing of office visits with evaluation and management codes and the office visits on these dates of service were not denied for medical necessity. Per the Medical Fee Guideline effective 08-01-03 reimbursement in the amount of **\$146.97** (\$39.19 X 125% = \$48.99 X 3 DOS) is recommended.

CPT code **97150** date of service 02-16-04 denied with code "MU" (physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code on the same date of service). The Trailblazer Local Coverage Determination (LCD) states in part, "When both a modality/procedure and an evaluation is clearly documented. Standard medical practice may be one or two visits in addition to physical therapy therapy treatments. Reimbursement beyond this standard utilization requires documentation supporting the medical

necessity for the office visit". The LCD does not prohibit the billing of evaluation and management codes with office visits and the evaluation and management codes on these dates of service were not denied for medical necessity. Per the Medical Fee Guideline effective 08-01-03 reimbursement in the amount of **\$22.60** (\$18.08 X 125%) is recommended.

**RATIONALE 97110:** 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 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 (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

### **ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 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(b); 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 01-19-04 through 02-25-04 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 Findings and Decision and Order are hereby issued this 14<sup>th</sup> day of October 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

Amended Report

10/11/2004

Hilda Baker  
TWCC Medical Dispute Resolution  
7551 Metro Center Suite 100  
Austin, TX 78744

Patient:  
TWCC #:  
MDR Tracking #: M5-04-2807-01  
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor with a specialty in Rehabilitation. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

\_\_\_ was injured on \_\_\_ when he was involved in a motor vehicle accident. He underwent a lumbar surgery in September of 2003. He presented to the office of Dr. K on 1/15/04. He underwent an active rehabilitation program with concomitant passive therapies to the knee and lumbar spine. He was referred for a knee surgical consultation with Drs. T and M. The results of these consultations were not provided for review. He was also referred to Dr. L

#### DISPUTED SERVICES

Disputed services include: 95851- ROM, 97110 Therapeutic Exercises, 95833 Muscle Test, 97140 Manual Therapy, L1810 KO Elastic with joints, 97012 Mechanical Traction from 1/19/04 through 2/12/04.

#### DECISION

The reviewer disagrees with the previous adverse determination regarding the following services: 95851(1/19/04); 97110 (1/19/04, 1/21/04, 1/26/04, 1/28/04, 2/2/04, 2/5/04, 2/9/04, 2/11/04, 2/12/04) and 95833 (2/5/04).

The reviewer agrees with the previous adverse determination regarding all remaining services.

## BASIS FOR THE DECISION

The reviewer concurs that a physical medicine approach to treatment is appropriate in most soft tissue injuries. The reviewer indicates that passive modalities have no place in treatment at this late date of treatment as the patient is in a secondary level of care. The reviewer indicates the opinions are based upon the ACOEM Guidelines.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,