

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 April 30, 2004.

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 therapeutic exercises, 97110, office visits; 99212, 99213, and 99214; injured tendon/ligament/cyst, 20550; injection, J1020; manual therapeutic technique, 97140, massage therapy, 97124, and therapeutic activities, 97530 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 June 16, 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.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA reflected proof of submission.

- CPT Code G0283 for date of service 08/07/03. Per Commission Rule 134.202(b) and (c)(1) reimbursement in the amount of \$16.63 (13.30 x 125%) is recommended.
- CPT Code 99213 for date of service 08/20/03. Per Commission Rule 134.202(b) and (c)(1) reimbursement in the amount of \$66.19 (\$52.95 x 125%) is recommended.
- CPT Code 97110 for date of service 10/10/03. 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 of 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. Reimbursement not recommended.

- CPT Code 97530 (4 units) for date of service 10/10/03. Per Commission Rule 134.202(b) and (c)(1) reimbursement in the amount of \$145.92 ($\$29.18 \times 125\% = \36.48×4) is recommended.
- CPT Code 99214 for date of service 10/10/03. Per Commission Rule 134.202(b) and (c)(1) reimbursement in the amount of \$103.24 ($\$82.59 \times 125\%$) 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 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 dates of service 08/07/03 through 10/10/03 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 30th day of September 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO Decision

August 11, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Corrected items in dispute and dates of service.

Re: Medical Dispute Resolution
MDR #: M5-04-2821-01
TWCC#:
Injured Employee:
DOI:

SS#:
IRO Certificate No.: 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Physical Medicine and Rehabilitation and Pain Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: letter of medical necessity, office notes, physical therapy notes, physical performance test, EMG/NCV and radiology report.

Clinical History:

This claimant was injured on ___ sustaining severe lumbar and sacral sprain/strain. He refused to be off of work except for 2 weeks in July secondary to severe pain, and continued to work up to 10 hours per day. The records provided for review report considerable treatment and therapy. No disc or nerve involvement was present on MRI, and early degenerative changes in the L4-L5 facet joint were noted.

Disputed Services:

Therapeutic exercise, office visits, injured tendon/ligament/cyst, injection, manual therapeutic technique, therapeutic activities, and massage therapy during the period of 08/07/03 through 10/17/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

This claimant has undergone appropriate therapy for an adequate amount of time given the injury that he sustained. The medical records document continuous treatment from 05/19/03 through 10/17/03. Further therapy beyond 08/06/03 (the last office note documented prior to 08/14/03) that may have been needed could have been achieved in a home-based program.

Sincerely,