

MDR Tracking Number: M5-04-2961-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 5-10-04. The requestor submitted a letter of withdrawal for dates of service 5-28-03, 5-29-03, 7-23-03, 7-29-03, and 7-31-03 due to carrier payment.

The IRO reviewed office visits w/manipulation, additional manipulations, joint mobilization, myofascial release, therapeutic exercises, neuromuscular re-education, and electrical stimulation on 5-28-03 to 12-31-03.

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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 7-2-04, 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.

Codes 97265, 97250, 97110, 97112 for dates of service 6-4-03 through 7-22-03 had no EOBs submitted by either party. Codes 98941, 97140-59 (2 units billed), and 97112 for dates of service 8-1-03 through 10-30-03 had no EOBs submitted by either party. Per Rule 133.308(f)(3), the requestor is required to provide documentation of the request for and response to reconsideration, or, if the respondent failed to respond, convincing evidence of carrier receipt of that request. Requestor submitted convincing evidence of carrier receipt of request. Per Rule 133.308(g)(3), the carrier is required to provide any missing information required such as notices of adverse determinations of retrospective medical necessity, not provided by the requestor. The carrier's initial response to the medical dispute did not include the missing EOBs; therefore, the services with no EOBs provided by either party will be reviewed per the 1996 *Medical Fee Guideline* and the 2002 *Medical Fee Guideline*.

- Code 97265 - recommend reimbursement of \$43.00 x 21 days = \$903.00
- Code 97250 - recommend reimbursement of \$43.00 x 21 days = \$903.00
- Code 97112 - recommend reimbursement of \$35.00 x 21 days = \$735.00

- Code 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 no documentation was submitted to clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.
- Code 98941 – recommend reimbursement of $\$36.59 \times 125\% = \$45.74 \times 47 \text{ days} = \$2,149.78$.
- Code 97140-59 – recommend reimbursement of $\$27.24 \times 2 \text{ units} = \$54.48 \times 125\% = \$68.10 \times 47 \text{ days} = \$3,200.70$.
- Code 97112 – recommend reimbursement of $\$29.55 \times 125\% = \$36.94 \times 47 \text{ days} = \$1,736.06$.

The above Findings and Decision is hereby issued this 4th day of November 2004.

Dee Z. Torres
 Medical Dispute Resolution Officer
 Medical Review Division

ORDER

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 outlined above as follows:

- In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- 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 Order is applicable to dates of service 6-4-03 through 12-31-03 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 Order is hereby issued this 4th day of November 2004.

Hilda H. Baker, Manager
Medical Dispute Resolution
Medical Review Division

September 20, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2961-01
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 female who sustained a work related injury on ----- . The patient reported that while at work she slipped and fell injuring her back. The patient underwent x-rays of the cervical, thoracic, and lumbar spine. Initial treatment for this patient's condition included chiropractic modalities consisting of joint mobilization, myofascial therapy, lumbar traction, cervical traction, and rehabilitative services. On 4/29/02 the patient underwent a MRI of the lumbar spine that was reported to have revealed a moderate central disc herniation at L4-5 and a small central disc herniation at the L5-S1. On 6/10/02 the patient underwent a NCV/SSEP/DSEP that was reported to be normal. The patient continued with treatment

consisting of manipulations, joint mobilization, myofascial release, therapeutic exercises, neuromuscular reeducation, and electrical stimulation.

Requested Services

Office visit with manipulation, manipulation EA additional area, joint mobilization, myofascial release, therapeutic exercises, neuromuscular reeducation, electrical stimulation unattended 5/28/03 through 12/31/03.

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

Documents Submitted by Requestor:

1. No documents submitted

Documents Submitted by Respondent:

1. Peer Review 10/16/02
2. Treatment notes 5/28/03
3. Case review 5/14/03

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her back on -----. The ----- chiropractor reviewer indicated that the patient had sustained multiple disc involvement with pain in the low back and left leg. The ----- chiropractor reviewer noted that the pain is well documented as being discogenic. The ----- chiropractor reviewer indicated that the ultimate goal of any work injury treatment plan is to return the patient to work full duty without restrictions. The ----- chiropractor reviewer explained that the ultimate outcome in case such as this, after two years of either surgery or conservative care is relatively the same. The ----- chiropractor reviewer noted that the patient declined surgery or injections. The ----- chiropractor reviewer also noted that the patient had been treated with conservative care. The ----- chiropractor reviewer indicated that the treating doctor presented several research articles that demonstrated the efficacy and time frame of what he was trying to accomplish with this patient's treatment. The ----- chiropractor reviewer explained that three designated doctor evaluations indicated that this patient was not a maximum medical improvement and would benefit from either conservative care, injections or surgery. The ----- chiropractor reviewer indicated that the patient chose conservative care. Therefore, the ----- chiropractor consultant concluded that the office visit with manipulation, manipulation EA additional area, joint mobilization, myofascial release, therapeutic exercises, neuromuscular reeducation, electrical stimulation unattended 5/28/03 through 12/31/03 were medically necessary to treat this patient's condition.

Sincerely,