

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-4351.M5

MDR Tracking Number: M5-04-3087-01

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 4-23-04.

The IRO reviewed medical necessity of office visits, mechanical traction, therapeutic exercises, chiropractic manipulative treatments, therapeutic exercises (group), special reports, biofreeze gel, electrical stimulator pads, muscle testing and massage.

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO concluded that electrical stimulator pads, special report and/or record copying charges (99080), massages (97124) and chiropractic manipulative therapies (98940) were medically necessary. All other services were not medically necessary.

On this basis, the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On June 28, 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 14 days of the requestor's receipt of the Notice.

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

Neither party in the dispute submitted original EOBs for the disputed services identified below with denial “D”. The Medical Review Division will review these services to determine if they are a duplicate of services rendered on this date. If not, they will be reviewed per *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
5-6-03 5-8-03	97750MT	\$215.00 \$258.00	\$0.00	E	\$43.00/body area	Medicine GR (I)(E)(3) and (I)(D)	The insurance carrier inappropriately denied based upon “E”. Testing was to compensable lumbar spine. Reimbursement per MFG of one body area of \$43.00 X 2 dates = \$86.00 is recommended.
9-17-03 11-20-03	99080 (61) (155)	\$30.50 \$77.50	\$0.00	F	\$.50	Rule 133.106	MAR reimbursement of \$30.50 + \$77.50 = \$108.00 is recommended.
9-30-03	95851	\$30.60	\$0.00	G	\$30.50	CPT Code Descriptor	ROM testing is not global to muscle testing or office visit rendered on this date, reimbursement of \$30.50 is recommended.
10-3-03	97124	\$25.69	\$0.00	G	\$25.69	CPT Code Descriptor	Massage therapy is not global to chiropractic manipulation, physical therapy service or office visit rendered on this date, reimbursement of \$25.69 is recommended.
10-3-03 11-17-03 11-17-03	A9150	\$8.00	\$0.00	D	\$8.00	CPT Code Descriptor	Reimbursement of \$24.00 is recommended.
10-8-03 11-7-03 11-10-03 11-12-03 11-14-03 12-4-03	98940	\$30.13	\$0.00	D	\$30.13	CPT Code Descriptor	MAR reimbursement of \$30.13 X 6 dates = \$180.78
11-7-03	99212-25	\$41.91	\$0.00	D	\$41.91	CPT Code Descriptor	MAR reimbursement of \$341.91 is recommended.
11-7-03 12-4-03	97012	\$17.20	\$0.00	D	\$17.20	CPT Code Descriptor	MAR reimbursement of \$17.20 X2 dates = \$34.40.
11-7-03 11-10-03 11-12-03 11-14-03	97110 (8)	\$260.00	\$0.00	D	\$32.64	CPT Code Descriptor	See Rationale Below

11-7-03 11-10-03 11-12-03 11-14-03	97150	\$21.37	\$0.00	D	\$21.37	CPT Code Descriptor	MAR reimbursement of \$21.37 X 4 dates = \$85.48 is recommended.
11-12-03	99211-25	\$23.35	\$0.00	D	\$23.35	CPT Code Descriptor	MAR reimbursement of \$23.35 is recommended.
11-17-03	97750(2)	\$66.80	\$0.00	D	\$33.40 X 2 = \$66.80	CPT Code Descriptor	MAR reimbursement of \$66.80 is recommended.
12-4-03	97124	\$25.69	\$0.00	D	\$25.70	CPT Code Descriptor	MAR reimbursement of \$25.69 is recommended.
TOTAL							The requestor is entitled to reimbursement of \$ 1032.60.

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.

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 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 Decision is applicable for dates of service 5-6-03 through 12-4-03 in this dispute.

This Order is hereby issued this 20th day of January, 2005.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

Amended Independent Review Decision

August 10, 2004

David Martinez
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-04-3087-01
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. 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

___ is a 44 year of age female cook who on ___ was working in the wash area of the kitchen when she lifted a stock pot full of water and began having pain in her lower back and right leg. After a trial with a medical doctor, she changed treating doctors and began with chiropractic care on 4/15/03. She then received chiropractic manipulations, physical therapy, rehabilitation, chronic pain management and injections.

DISPUTED SERVICES

Disputed services include: Office visits (99211-25 and 99212-25), mechanical traction, therapeutic exercises, chiropractic manipulative treatments, therapeutic exercises (group), special

reports, biofreeze gel, electrical stimulator pads, muscle testing (97750) and massage for DOS 5/13/03 through 12/4/03. (excluding DOS 9/17/03, 9/30/03, 10/8/03, 11/7/03 and 11/17/03) Supplies were reviewed on 10/3/03 and only the office visit for DOS 12/4/03).

DECISION

The reviewer disagrees with the previous adverse determination for the following services: electrical stimulator pads, special reports and/or record copying charges (99080), massages (97124) and chiropractic manipulative therapies (98940).

All other services are denied.

BASIS FOR THE DECISION

The reviewer indicates that the decision is based upon the following: The medical necessity of the Bao Zhen Gao analgesic patches and the biofreeze gel was not adequately substantiated in the records. However, the necessity of the electrical stimulation pads as well supported. The manipulations were approved because the designated doctor and the RME doctor felt that care was necessary during this time frame. The full spine mechanical tractions were denied because the records did not indicate the medical necessity of traction to the cervical or thoracic spines. The minimal office visits were denied because this limited, brief level of E/M service is a component of CMT in terms of the “pre-service work.” Therefore, performing a separate service is not supported. The 99212-25 was denied because neither the diagnosis nor severity of injury required the performance of this level of E/M service on each patient encounter. The therapeutic exercise and group exercise were not indicated due to the length of time the patient had been receiving supervised care (April through October). The reviewer indicates that a home exercise program would have likely provided the same level of improvement. Moreover, the treating doctor failed to document the medical necessity of the muscle testing performed on 10-29-2003, or how the data obtained from this test would impact the patient’s treatment plan. The reviewer bases the above listed basis of decision based upon TLC 413.011 (indicates TWCC must use the reimbursement policies and guidelines promulgated by the Medicare system) and “physical medicine and rehabilitation for orthopedic and musculoskeletal diseases and/or injuries” reimbursement policies as applicable to the Texas Medicare System.

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,

Wendy Perelli, CEO
CC: Specialty IRO Medical Director