

MDR Tracking Number: M5-04-3168-01

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 5-21-04.

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 the therapeutic exercises, office visits, group therapeutic procedures, chiropractic manipulative treatment, manual therapy, neuromuscular re-education, supplies and ultrasound from 11-5-03 through 3-18-04 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute 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 7-6-04, 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.

Regarding CPT Code 97110 for dates of service 10-27-03, 10-28-03, 10-30-03, 10-31-03, 11-3-03, and 12-01-03 recent review of disputes involving 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 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. **Additional reimbursement not recommended.**

CPT Code 99212 for dates of service 10-27-03, 10-30-03, 10-31-03, 11-3-03, and 1-7-04 were denied by the Insurance Carrier. Neither the requestor nor the respondent submitted initial EOB's and did not timely respond to the request for additional information. These dates of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$233.67. (\$46.41 x 4 plus \$48.03)**

CPT Code 98941 for date of service 10-27-03 was denied with an "O" - denial after reconsideration. Neither the requester nor the respondent submitted initial DOB's. This date of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. **Reimbursement is recommended in the amount of \$45.60.**

CPT Code 97012 for date of service 10-27-03 was denied with an "O" - denial after reconsideration. Neither the requester nor the respondent submitted initial DOB's. This date of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$18.83.**

CPT Code 97150 for date of service 10-27-03 was denied with an "O" - denial after reconsideration. Neither the requester nor the respondent submitted initial DOB's. This date of service of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$23.61.**

CPT Code 72110 for date of service 10-27-03 was denied with an “O” - denial after reconsideration. Neither the requester nor the respondent submitted initial DOB’s. This date of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$66.08.**

CPT Code 97032 for dates of service 10-28-03 and 10-30-03 was denied with an “O” - denial after reconsideration. Neither the requester nor the respondent submitted initial DOB’s. This date of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$41.36. (\$20.68 x 2.)**

CPT Code 97124 for dates of service 10-28-03, 10-31-03, and 11-3-03 was denied with an “O” - denial after reconsideration. Neither the requester nor the respondent submitted initial DOB’s. This date of service of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$84.42. (\$28.14 x 3)**

Regarding CPT Code 98940 for dates of service 10-28-03, 10-31-03, 11-3-03, and 12-01-03, 1-6-04, 1-7-04, 2-20-04, and 2-25-04: neither the requestor nor the respondent submitted initial EOB’s and did not timely respond to the request for additional information. These dates of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$264.60. (\$32.84 x 4 plus \$33.31 x 4)**

Regarding CPT Code 97112 for dates of service 10-28-03 and 11-26-03: Neither the requestor nor the respondent submitted initial EOB’s and did not timely respond to the request for additional information. These dates of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$73.38. (\$36.69 x 2)**

CPT Code 97140 date of service 12-01-03 was denied with an “O” - denial after reconsideration. Neither the requester nor the respondent submitted initial DOB’s. This date of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. **Reimbursement is recommended in the amount of \$33.90.**

Regarding CPT Code 99213 for date of service 1-6-04: Neither requestor nor the respondent submitted EOB’s and did not timely respond to the request for additional information. These dates of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. **Reimbursement is recommended in the amount of \$67.25.**

Pursuant to 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.

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 14th day of October 2004.

Donna Auby

Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

August 10, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-3168-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 28 year-old male injured his back on ____ and had a diskectomy on 07/14/03. He continues with low back pain with radicular symptoms. He has been receiving chiropractic treatment and was treated in a work hardening program from December 2003 until February 2004. His current diagnoses are lumbar facet disease, lumbar radiculopathy, lumbar disc degeneration, low back pain, myofascial back syndrome, and central canal stenosis and he continues with physical therapy treatments.

Requested Service(s)

Therapeutic exercises, office visits, group therapeutic procedures, chiropractic manipulative treatment, manual therapy, neuromuscular re-education, supplies and ultrasound from 11/05/03 through 03/18/04.

Decision

It is determined that the therapeutic exercises, office visits, group therapeutic procedures, chiropractic manipulative treatment, manual therapy, neuromuscular re-education, supplies and ultrasound were not medically necessary for the treatment of this patient's condition from 11/05/03 through 03/18/04

Rationale/Basis for Decision

The medical information provided lacks documentation to support the medical necessity for any of the treatment rendered during the specified dates. Therapeutic exercises may be performed in a clinic one-on-one setting, in a clinic group, at a gym, or at home. The least costly of these options is for the exercises to be performed at home. A home exercise program is also preferable because the patient can perform them on a daily basis. No justification has been provided for the need for one-on-one therapy. Furthermore, even if one-on-one therapy had been medically necessary at some point, it would not have been needed for the duration of time in this case.

There is also no documentation to support the medical necessity of the treatments since much of the care was performed at the very same time that a work hardening treatment program was in progress.

Finally, the treatments failed to relieve the effects of the injury, promote recovery, or enhance the ability of the patient to return to work. That position is documented by the 10/27/03 and 01/06/04 examinations that revealed the exact same limited lumbar ranges of motion, the 12/11/03 and 02/26/04 functional capacity evaluations that revealed insignificant improvement in the lumbar ranges of motion, and the subsequent need for lumbar epidural steroid injections after the dates in questions.

Therefore, the therapeutic exercises, office visits, group therapeutic procedures, chiropractic manipulative treatment, manual therapy, neuromuscular re-education, supplies and ultrasound from 11/05/03 through 03/18/04 were not medically necessary for the treatment of this patient's condition.

Sincerely,