

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on May 28, 2004 .

The IRO reviewed manual therapy, office visits, therapeutic activities, manual muscle testing, for dates of service 08/18/03 through 10/28/03, that were denied based upon “U” or “V”.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

The manual therapy for date of service 08/18/03 **was** found to be medically necessary. The office visits, therapeutic activities, manual muscle testing **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for manual therapy, office visits, therapeutic activities, manual muscle testing.

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.

On September 13, 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.

- CPT Code 97112 (8 units total) for dates of service 10/21/03 through 10/28/03. EOBs were not submitted by either party; therefore, these dates of service will be reviewed according to Rule 134.202 and the Medicare Fee Schedule. Per Rule 134.202(b) and (c)(1) and the Medicare Fee Schedule reimbursement in the amount of \$295.52 ($\$29.55 \times 125\% = \36.94×8) is recommended.
- CPT Code 97530 (4 units total) for dates of service 10/21/03 through 10/28/03. EOBs were not submitted by either party; therefore, these dates of service will be reviewed according to Rule 134.202 and the Medicare Fee Schedule. Per Rule 134.202(b) and (c)(1) and the Medicare Fee Schedule reimbursement in the amount of \$145.92 ($\$29.18 \times 125\% = \36.48×4) is recommended.

- CPT Code 97110 (4 units) for date of service 10/23/03. EOBs were not submitted by either party; therefore, this date of service will be reviewed according to TWCC rules. 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
- HCPCS Code E0745 for date of service 10/23/03. EOBs were not submitted by either party; therefore, this date of service will be reviewed in accordance with Rule 134.202 and the DMEPOS Fee Schedule. Per Rule 134.202(d) reimbursement in the amount of \$111.34 (amount in dispute and reflected on the Table of Disputed Services) is recommended.
- CPT Code 99212 for date of service 12/02/03. EOBs were not submitted by either party; therefore, this date of service will be reviewed in accordance with Rule 134.202 and the Medicare Fee Schedule. Per Rule 134.202(c)(1) and the Medicare Fee Schedule, reimbursement in the amount of \$47.23 (\$37.78 x 125%) is recommended.
- CPT Code 99080 for date of service 12/02/03. EOBs were not submitted by either party. MDR cannot distinguish what is in dispute. Review of the HCFA-1500 does not list a modifier and the submitted SOAP note for this date of service does not report that supplies were issued to the claimant. Per Rule 133.307(g)(3)(B) reimbursement is not 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 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 08/18/03 and 10/21/03 through 12/02/03 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 Order is hereby issued this 4th day of November, 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO decision

MEDICAL REVIEW OF TEXAS
[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3275-01
Name of Patient:	
Name of URA/Payer:	Central Dallas Rehab
Name of Provider: (ER, Hospital, or Other Facility)	Central Dallas Rehab
Name of Physician: (Treating or Requesting)	Christopher Plate, DC

July 27, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the

special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Rosalinda Lopez, Texas Workers Compensation Commission

CLINICAL HISTORY

The patient received physical medicine treatments after he injured his low back in a fall at work on ____.

REQUESTED SERVICE(S)

Manual therapy techniques - one or more regions - 15 minutes (97140), Office Visits (99212), Therapeutic Activities (97530), Office Visit (99213) and Manual Muscle Testing (95831) on DOS 08/18/03, 10/15/03, 10/21/03, 10/22/03, 10/23/03 and 10/28/03.

DECISION

The care rendered on 8/18/03 is approved. All other treatment is denied.

RATIONALE/BASIS FOR DECISION

Based on the 08/15/03 initial examination, treatment for six weeks would be indicated for the injury that was sustained. According to the initial recommendations contained in the

doctor's examination report and the correspondence from the doctor's collection department, the patient received treatment

during this six week time period. Therefore, the treatment on 08/18/03 is approved.

For all practical purposes, legitimate daily progress notes regarding the patient's treatment and response to care were not furnished since the treatment notes were almost verbatim for each and every visit for the dates in question. As a result, there was no documentation supplied to support the medical necessity for further treatment beyond six weeks. Moreover, the doctor reported "decreased" lumbar ranges of motion but he failed to record the degrees so there was no way to objectively monitor the patient's response to care.

The medical records submitted also failed to document that chiropractic spinal adjustments were performed at any time. According to the AHCPR¹ guidelines, spinal manipulation was the only treatment that could relieve symptoms, increase function and hasten recovery for adults suffering from acute low back pain. Given that spinal manipulation was not included in the treatment regimen, it is not at all surprising that the patient's subjective low back pain rating was 5 at the initiation of care and remained at that same level on 10/23/03 after undergoing 8 weeks of care.

¹ Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December 1994.