

MDR Tracking Number: M5-04-3292-01

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 5-28-04.

In a letter dated 11-17-04 the requestor withdrew all dates of service between 6-9-03 and 6-24-03 except for CPT codes 97250 and 97110 on 6-10-03, CPT codes 97112, 97250, 97150 and 97110 on 6-11-03 and CPT code 97110 on 6-24-03.

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 office visit – level IV-new patient, therapeutic exercises, neuromuscular re-education, aquatic therapy, myofascial release and group therapy from 6-2-03 through 6-6-03 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 10-12-04 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. **Per Rule 133.307(g)(3) the respondent sent no additional information.**

- CPT codes 97112 for date of service 6-11-03 was denied with a “W” – not timely filed. However the requester has sent documents to verify that this service was submitted timely. **Recommend reimbursement of \$35.00.**
- CPT code 97250 for dates of service 6-10-03 and 6-11-03 were denied by the insurance carrier with a “W” – not timely filed. The requester has submitted documents verifying that the bills were submitted timely. **Recommend reimbursement of \$86.00. (\$43.00 x 2).**
- Regarding CPT code 97110 for dates of service 6-10-03, 6-11-03 and 6-24-03: these were denied either with a “W” – not timely filed or with an “F” – Fee guideline MAR reduction. 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.**

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 the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- 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 18th of November 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

August 9, 2004

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

Re: Medical Dispute Resolution
MDR #: M5-04-3292-01
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 the Secretary and General Counsel of ___ 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 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, correspondence, office notes and MRI.

Information provided by Respondent: correspondence.

Clinical History:

On ___ this claimant injured his back while on his job. Very little documentation was provided for the period of time and services in dispute. The documentation provided is confusing and the reviewer had difficulty separating the information between two referenced injuries (02/05/02 and ___) and two separate surgeries. The patient's diagnosis is unclear, but there is reference to herniated nucleus pulposus in the records – lumbar HNP.

Apparently, the claimant has been having therapy before and after the dates in question. On the 2nd, 3rd, 4th, 5th, and 6th the list of disputed services indicates two services provided on the 2nd. It appears that these were the evaluations; then, four services on the 3rd, 4th, 5th and the 6th of June. Similar services are provided thereafter. Again, most of the documents have nothing to do with the issues in question. Some of the therapy notes have the date cut off on them, making it unclear if they cover this period. The therapy notes, which cover this period are done on June 2, 2003, and the evaluation is for decreased active motion, decreased strength, and myofascial descriptions. The plan is for therapeutic procedures, therapeutic activities, myofascial release, neuromuscular reeducation and aquatic therapy.

Report of the first MRI states there is a posterocentral disc protrusion with associated posterior disc bulge at L5-S1 without thecal sac impingement. This indicates that there is a rather minimal injury and compared to an MRI done a little over a year before that, which is the same, again would indicate minimal structural defects present.

In reviewing the therapies, there was one listing of therapies that is applicable to this period, and this says the patient had therapy from 8:30 to 3:00 p.m. The other notes are outside of the areas of the time frame in question, except for the evaluation. This makes it extremely difficult to see if any of this work was done with the patient. There was one note on June 2, 2003 in addition to the lumbar evaluation. This was a rather lengthy note, which may indicate that it was for evaluation. There was one listing dated June 4, 2003 referring to the February 5, 2002 injury, and this gives a progress summary. This note is almost illegible, but states that the patient's attitude is marginal. It says the patient will participate but requires coaxing. Other similar notes indicate the patient is manipulative, a game player, partied often, has poor follow through, and begins to raise expectations.

Other notes, July 2, 2003 for example, which were outside the time period but in the same therapy group, states the claimant requires motivation from therapist to complete all tasks. There is a note indicating his motivation is very high. All other notes are out of the period in dispute.

Disputed Services:

Office visit-level IV-new patient, therapeutic exercises, neuromuscular re-education, aquatic therapy, myofascial release and group therapy during the period of 06/02/03 through 06/06/03.

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:

It seems that even the Requestor's criteria for the therapy is really not being met. Namely, that there is a clear off-line of the base of treatment, time of treatment, and response to treatment. It is anything but clear as to what is going on and what therapies were given over a 6-7 hour day.

The progress notes do not show improvement over that period of time. The therapy continued much, much longer. Thus, there is no evidence that the therapy was goal-directed. Though it seems there was an attempt made to work with the patient hard enough to get him back to the difficult manual labor job, which he does. Apparently, that is why there were 6-7 hours of therapy done on therapy days. The clock times sheets checked him in at about 8:15 or prior, and then checking out about 3:30 or 3:40 in the afternoon.

Again, it is an extremely difficult determination to make as there are very few documents that pertain to the disputed time period June 2, 2003 through June 6, 2003, and they are not clear at best. Thus, there is no data presented showing that the treatment was appropriate, that it was goal-directed, that it had any value, and that the patient was interested in doing the therapy. Thus, the reviewer must conclude without any evidence to the contrary that the treatment and services in dispute were not medically necessary.

Sincerely,