

MDR Tracking Number: M5-04-3352-01

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 6-1-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the issues of medical necessity. The IRO agrees with the previous determination that myofascial release, durable medical equipment and replacement batteries for a TENS unit from 6-9-03 through 7-18-03 are medically necessary. However, the office visits, therapeutic exercises, joint mobilization, manual traction, non-emergency transportation, neuromuscular stimulator, and lidocaine injections for 6-9-03 through 7-18-03 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 7-15-03, 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 Contested Case Hearing of 2-13-04 resulted in these Conclusions of Law: "Claimant sustained a compensable repetitive trauma injury....Claimant is entitled to medical benefits for his injury."

No EOB's were submitted by either the Insurance Carrier or the Requestor for CPT codes 99213, 97265, 97250 or 97122 on dates of service 7-3-03, 7-7-03, 7-9-03. There is no "convincing evidence of the carrier's receipt of the provider request for an EOB" according to 133.307 (e)(2)(B) **No reimbursement recommended.**

The insurance carrier originally denied CPT code 99213 for dates of service 6-9-03, 6-10-03, 6-11-03, 6-20-03, 6-23-03, 6-24-03, 6-25-03 (2), 6-26-03 (2), 6-27-03, 6-30-03, 7-1-03, 7-2-03, 7-14-03, 7-16-03, 7-17-03 with an "E" (Entitlement). The carrier did reaudit these dates and provided the statement – Denial of payment resulting after a reconsideration. The carrier also denied these services as "777 – Based on the diagnosis, treatment patterns, and/or number of visits, the treatments exceed our physician parameters. Refer to Dr. report." Pursuant to Rule 133.304(c) "The explanation of benefits shall include the correct payments exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)." The carrier's EOB denials are unclear. Therefore, these services will be reviewed in accordance with the 1996 Medical Fee Guidelines. The requestor has provided no HCFA's or medial documentation to support why this code was billed twice for 6-25-03 and 6-26-03. The Table of Disputed Services does not indicate a modifier was used to bill these services. Therefore, no reimbursement is recommended for one of the two office visits on these two days. **Reimbursement is recommended in the amount of \$720.00. (\$48.00 x 15)**

The insurance carrier originally denied CPT code 97265 for dates of service 6-9-03, 6-10-03, 6-11-03, 6-12-03, 6-13-03, 6-16-03, 6-17-03, 6-18-03, 6-19-03, 6-20-03, 6-23-03, 6-24-03, 6-25-03 -2-(CPT code descriptor describes one or more areas. This service can't be billed twice on the same day), 6-27-03, 6-30-03, 7-1-03, 7-2-03, 7-11-03, 7-14-03 and 7-16-03 with an "E" (Entitlement). The carrier did reaudit these dates and provided the statement – Denial of payment resulting after a reconsideration. The CCH of

2-13-04 resulted in these Conclusions of Law: "Claimant sustained a compensable repetitive trauma injury....Claimant is entitled to medical benefits for his injury." The carrier also denied these services as "777 – Based on the diagnosis, treatment patterns, and/or number of visits, the treatments exceed our physician parameters. Refer to Doctor report." Pursuant to Rule 133.304(c) "The explanation of benefits shall include the correct payments exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)." The carrier's EOB denials are unclear. Therefore, these services will be reviewed in accordance with the 1996 Medical Fee Guidelines. **Reimbursement is recommended in the amount of \$860.00. (\$43.00 x 20)**

The insurance carrier originally denied CPT code 97250 for dates of service 6-9-03, 6-10-03, 6-11-03, 6-12-03, 6-13-03, 6-16-03, 6-17-03, 6-18-03, 6-19-03, 6-20-03, 6-23-03, 6-24-03, 6-25-03-2 (CPT code descriptor describes one or more areas. This service can't be billed twice on the same day), 6-26-03, 6-27-03, 7-1-03, 7-2-03, 7-11-03, 7-14-03 and 7-16-03 with an "E" (Entitlement). The carrier did reaudit these dates and provided the statement – Denial of payment resulting after a reconsideration." The carrier also denied these services as "777 – Based on the diagnosis, treatment patterns, and/or number of visits, the treatments exceed our physician parameters. Refer to Doctor report." Pursuant to Rule 133.304(c) "The explanation of benefits shall include the correct payments exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)." The carrier's EOB denials are unclear. Therefore, these services will be reviewed in accordance with the 1996 Medical Fee Guidelines. **Reimbursement is recommended in the amount of \$860.00. (\$43.00 x 20)**

The insurance carrier originally denied CPT code 97122 for dates of service 6-9-03, 6-10-03, 6-11-03, 6-12-03, 6-13-03, 6-16-03, 6-17-03, 6-18-03, 6-19-03, 6-20-03, 6-23-03, 6-24-03, 6-25-03 (2 units), 6-26-03, 6-27-03, 6-30-03, 7-1-03, 7-2-03, 7-11-03, 7-14-03 and 7-16-03 with an "E" (Entitlement) or no EOB was provided. The carrier did reaudit these dates of service and provided the statement – Denial of payment resulting after a reconsideration." The carrier also denied these services as "777 – Based on the diagnosis, treatment patterns, and/or number of visits, the treatments exceed our physician parameters. Refer to Doctor report." Pursuant to Rule 133.304(c) "The explanation of benefits shall include the correct payments exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)." The carrier's EOB denials are unclear. Therefore, these services will be reviewed in accordance with the 1996 Medical Fee Guidelines. **Reimbursement is recommended in the amount of \$770.00. (\$35.00 x 22)**

The insurance carrier originally denied CPT code 97110 for dates of service 6-9-03, 6-10-03, 6-11-03, 6-12-03, 6-13-03, 6-16-03, 6-17-03, 6-18-03, 6-19-03, 6-20-03, 6-23-03, 6-24-03, 6-25-03, 6-26-03, 6-27-03, 6-30-03, 7-1-03, 7-2-03, 7-3-03, 7-7-03, 7-9-03, 7-11-03, 7-14-03 and 7-16-03 with an "E" (Entitlement) or no EOB was provided. 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. **Reimbursement not recommended.**

The insurance carrier originally denied CPT code 76856wp for date of service 6-20-03 with an "E" (Entitlement). The carrier did reaudit this date of service and provided the statement – Denial of payment resulting after a reconsideration." The carrier also denied these services as "777 – Based on the diagnosis,

treatment patterns, and/or number of visits, the treatments exceed our physician parameters. Refer to Doctor report.” Pursuant to Rule 133.304(c) “The explanation of benefits shall include the correct payments exception codes required by the Commission’s instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier’s action(s).” The carrier’s EOB denials are unclear. Therefore, these services will be reviewed in accordance with the 1996 Medical Fee Guidelines. **Reimbursement is recommended in the amount of \$151.00. (MAR)**

The insurance carrier originally denied CPT code 76800wp for date of service 6-20-03 with an “E” (Entitlement). The carrier did reaudit this date of service and provided the statement – Denial of payment resulting after a reconsideration.” The carrier also denied these services as “777 – Based on the diagnosis, treatment patterns, and/or number of visits, the treatments exceed our physician parameters. Refer to Doctor report.” Pursuant to Rule 133.304(c) “The explanation of benefits shall include the correct payments exception codes required by the Commission’s instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier’s action(s).” The carrier’s EOB denials are unclear. Therefore, these services will be reviewed in accordance with the 1996 Medical Fee Guidelines. **Reimbursement is recommended in the amount of \$188.00. (MAR)**

The insurance carrier originally denied CPT code 76970 for date of service 6-20-03 with an “E” (Entitlement). The carrier did reaudit this date of service and provided the statement – Denial of payment resulting after a reconsideration.” The carrier also denied these services as “777 – Based on the diagnosis, treatment patterns, and/or number of visits, the treatments exceed our physician parameters. Refer to Doctor report.” Pursuant to Rule 133.304(c) “The explanation of benefits shall include the correct payments exception codes required by the Commission’s instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier’s action(s).” The carrier’s EOB denials are unclear. Therefore, these services will be reviewed in accordance with the 1996 Medical Fee Guidelines. **Reimbursement is recommended in the amount of \$89.00. (MAR)**

The insurance carrier originally denied CPT code 20550 for date of service 7-17-03 with an “E” (Entitlement). The carrier did reaudit this date of service and provided the statement – Denial of payment resulting after a reconsideration.” However, the CCH of 2-13-04 resulted in these Conclusions of Law: “Claimant sustained a compensable repetitive trauma injury....Claimant is entitled to medical benefits for his injury.” The carrier also denied these services as “777 – Based on the diagnosis, treatment patterns, and/or number of visits, the treatments exceed our physician parameters. Refer to Doctor report.” Pursuant to Rule 133.304(c) “The explanation of benefits shall include the correct payments exception codes required by the Commission’s instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier’s action(s).” The carrier’s EOB denials are unclear. Therefore, these services will be reviewed in accordance with the 1996 Medical Fee Guidelines. **Reimbursement is recommended in the amount of \$40.00. (MAR)**

This Finding and Decision is hereby issued this 14<sup>th</sup> day of December 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

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. This Decision is applicable for dates of service 6-9-03 through 7-17-03 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 14<sup>th</sup> day of December 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

Enclosure: IRO decision

#### NOTICE OF INDEPENDENT REVIEW DECISION

August 19, 2004

**Amended Letter 11/08/04**

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 #: M5-04-3352-02  
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 §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 TMF physician reviewer who is board certified in physical medicine and rehabilitation which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1979. The TMF physician reviewer 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 25 year-old male injured his back on \_\_\_\_, resulting in continued pain in his lower back and bilateral lower extremities. He has been treated with extensive conservative measures including

physical therapy, epidural steroid injections, and chiropractic treatment with little improvement. His diagnosis is listed as lumbar disc herniation and spinal stenosis.

Requested Service(s)

Office visits, therapeutic exercises, joint mobilization, manual traction, myofascial release, non-emergency transportation, neuromuscular stimulator, durable medical equipment, replacement batteries for a TENS unit, and lidocaine injection with dates of service of 06/09/03 through 07/18/03.

Decision

It is determined that the myofascial release, durable medical equipment and replacement batteries for a TENS unit are medically necessary to treat this patient's medical condition. However, the office visits, therapeutic exercises, joint mobilization, manual traction, non-emergency transportation, neuromuscular stimulator, and lidocaine injections for dates of service of 06/09/03 through 07/18/03 were not medically necessary to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates the patient has undergone multiple treatments and physical therapy with no sustained relief of pain or improved function. The office visits, therapeutic exercises, joint mobilization, manual traction, non-emergency transportation, neuromuscular stimulator, and lidocaine injections are those used to treat acute rather than subacute problems. Therefore, they are not medically necessary. However, the myofascial release, durable medical equipment (TENS), and replacement batteries for a TENS unit are medically necessary as they can reduce pain in lieu of pain medication.

Therefore, the myofascial release, durable medical equipment and replacement batteries for a TENS unit are medically necessary to treat this patient's medical condition. However, the therapeutic exercises, joint mobilization, manual traction, non-emergency transportation, neuromuscular stimulator, and lidocaine injections for dates of service of 06/09/03 through 07/18/03 were not medically necessary to treat this patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:vn

Attachment

## Information Submitted to TMF for TWCC Review

**Patient Name:**

**TWCC ID #: M5-04-3352-02**

### **Information Submitted by Requestor:**

- TWCC Compensation Commission decision and order
- Table of disputed services
- Therapy notes 06/09/03-07/18/03
- Physical performance evaluation 06/12/03 & 07/11/03
- Office notes 07/13/03-07/17/03
- Orthopedic surgery evaluation 05/06/04
- MRI report
- EMG/NCS report

### **Information Submitted by Respondent:**

- IRO Summary 07/19/04
- Retrospective medical review 06/26/03-08/12/03
- First report of injury
- Office notes 05/09/03-06/21/04
- Physical performance evaluation 05/12/03-09/18/03
- MRI report
- EMG/NCS report
- Therapy notes 05/12/03-06/30/04