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

SOAH DOCKET NO. 453-05-3066.M5

MDR Tracking Number: M5-04-3453-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 June 10, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the issues of medical necessity. The office visits, electrical stimulation, ultrasound, hot/cold pack therapy, myofascial release, chiropractic manipulative treatment, therapeutic exercises, massage, and electrical stimulation unattended denied with U from 06-03-03 through 10-22-03 and the office visit rendered on 01-29-04 **were** medically necessary. The electrical stimulation, ultrasound, hot/cold pack therapy, myofascial release, chiropractic manipulative treatment, therapeutic exercises, massage, and electrical stimulation unattended denied with U from 10-24-03 through 02-05-04 **were not** medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

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 09-08-04, 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.

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

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
08-01-03	97032 97035 97124	$20.68 $15.23 $28.14	$0.00	F	$20.68 $15.57 $28.14	Medicare Fee Schedule Rule 134.202 (d)	In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Therefore, reimbursement is recommended in the amount of $64.05.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
08-05-03	97032 97035 97124	$20.68 $15.23 $28.14	$0.00	F	$20.68 $15.57 $28.14	Medicare Fee Schedule Rule 134.202(d)	In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Therefore, reimbursement is recommended in the amount of $64.05.
08-06-03	97032 97035 97124	$20.68 $15.23 $28.14	$0.00	F	$20.68 $15.57 $28.14	Medicare Fee Schedule Rule 134.202(d)	In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Therefore, reimbursement is recommended in the amount of $64.05.
08-08-03	97032 97035 97124	$20.68 $15.23 $28.14	$0.00	F	$20.68 $15.57 $28.14	Medicare Fee Schedule Rule 134.202(d)	In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Therefore, reimbursement is recommended in the amount of $64.05.
08-12-03	97032 97035 97124	$20.68 $15.23 $28.14	$0.00	F	$20.68 $15.57 $28.14	Medicare Fee Schedule Rule 134.202(d)	In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Therefore, reimbursement is recommended in the amount of $64.05.
08-13-03	97032 97035 97124	$20.68 $15.23 $28.14	$0.00	F	$20.68 $15.57 $28.14	Medicare Fee Schedule Rule 134.202(d)	In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Therefore, reimbursement is recommended in the amount of $64.05.
08-15-03	97032 97035 97124	$20.68 $15.23 $28.14	$0.00	F	$20.68 $15.57 $28.14	Medicare Fee Schedule	In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted

						Rule 134.202(d)	relevant information to support delivery of service. Therefore, reimbursement is recommended in the amount of $64.05.
08-15-03 12-17-03 12-23-03	97110 97110 97110	$143.64 $179.55 $179.55	$0.00	F	$35.91 x 4 $35.91 x 5 $35.91 x 5	Medicare Fee Schedule Rule 134.202(d)	See rationale below for CPT code 97110.
08-20-03	99213	$65.21	$0.00	F	$67.25	Medicare Fee Schedule Rule 134.202(d)	In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Therefore, reimbursement is recommended in the amount of $65.21.
09-30-03	97750-FC	$400.00 (16units)	$293.52	F	$36.69 per unit	Medicare Fee Schedule Rule 134.202(d)	In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Therefore, additional reimbursement is recommended in the amount of $106.48.
12-17-03 & 12-23-03	98940 G0283 97124	$65.68 $35.92 $56.28	$0.00	No EOB's	$32.84 x 2 $16.46 x 2 $28.14 x 2	Medicare Fee Schedule Rule 134.202(d)	Neither the requestor nor the respondent submitted EOB's. However, the requestor submitted evidence that the carrier receieved the providers recon HCFA's by certified mail. Therefore, 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 $157.88.
TOTAL		$1574.18					The requestor is entitled to reimbursement of $777.92.

Rationale for CPT code 97110 - 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.

This Findings and Decision is hereby issued this 5th day of November 2004.

Medical Dispute Resolution Officer
Medical Review Division

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) and 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. This Order is applicable for dates of service 06-03-03 through 01-29-04 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 5th day of November 2004.

Medical Dispute Resolution
Medical Review Division

RL/pr

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 7, 2004 **AMENDED DECISION**

RE:
MDR Tracking #: M5-04-3453-01
IRO Certificate #: 5242

___ 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 ____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed 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 Chiropractic reviewer who has an ADL certification. The 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- It should be noted that voluminous amounts of explanation of benefits were provided for review along with a table of disputed dates of service.
- Letter of 8/9/04 explaining their position regarding the disputed dates of service
- Usual IRO documentation from the TWCC
- 8/7/04 Statement of Health Care Providers Position Letter
- Previous medical records including an MRI of the lumbar spine as well as discograms and post discogram CT scans of the lumbar spine.
- ____ impairment rating request of 1/3/01
- Initial patient history from ____
- Several follow up office visits including the recommendation for work hardening from ___
- FCE request of 4/9/01 from ____
- Recommendation for work hardening from ____ of 4/9/01 – the claimant was unable to complete the work hardening and according to the documentation provided for review only went through about 1 week of the work hardening program
- Impairment testing worksheet of 1/7/02 revealing the claimant to be at statutory MMI with 10% whole body impairment rating from ___
- Subsequent follow up visit of 1/15/02 from ____
- Note from ___ dated 2/12/02 stating the claimant has coronary artery disease and should be at low risk for cardiovascular complications from surgery
- Notations from ___ which is a community health center in the Houston area

- Change of treating physician form or TWCC-53 dated 7/5/02 requesting to change treating physicians to ___ – it appears ___ opted out of the workers' compensation system and this was the reason for the request. It should also be mentioned that ___ did refer the claimant to ___
- Initial medical report from ___ dated 8/1/02
- Note from ___ dated 3/5/03 who felt the claimant was a candidate for surgery
- Note from ___ of 4/7/03
- Chiropractic daily notes from 5/20/03 through 6/10/03 for 4 visits
- Additional chiropractic daily notes from 7/21/03 through 2/5/04 for approximately 60 visits
- Two notes from ___ dated 6/11/03 and 7/16/03
- Subsequent medical report from ___ dated 7/21/03
- Subsequent medical report from ___ dated 9/23/03
- FCE summary report of 9/30/03 revealing the claimant to be at the light to light medium duty level
- Behavioral assessment report from ____ dated 10/10/03 – it should be noted this report revealed the claimant's anxiety and depression to be minimal
- Subsequent medical report from ___ dated 10/21/03
- 3/3/04 note from ___ revealing that a follow up MRI revealed there to be some scar tissue surrounding the L5 nerve root which would be expected with the surgery the claimant had. It was felt there was no residual compressive abnormality and ___ felt that further operative intervention was not going to be a solution for the claimant. ___ at this time of 3/3/04 recommended a chronic pain management program.
- Discharge summary report from ___ dated 3/23/04 recommending a chronic pain management program. Additional supporting documentation revealed a medical dispute resolution finding and decision report regarding some of the earlier treatment provided prior to the surgery.
- Notice of independent review determination and again ___ office provided another table of disputed services. His documentation seemed to reveal that his office has not received payment for anything beyond 6/3/03, yet according to the documentation I reviewed, the provider was paid for manipulation and some of the active care billed at 97110 on 8/1 through 8/15 of the disputed dates of service. It appears the FCE of 9/30/03 was also paid and that for some reason massage therapy at code 97124 was paid on 8/1/03. This, again, is according to some explanation of benefits that were reviewed.

Submitted by Respondent:

- None submitted

Clinical History

According to the documentation submitted for review, the claimant suffered a slip and fall injury when he fell backwards while unloading a pallet of produce with a pallet jack on ___. A February 2000 MRI report revealed extensive degenerative changes and significant compression of the left L5 nerve root along with the usual amount of facet arthropathy at the L4 through S1 levels causing some foraminal stenosis at those levels. The discogram and post discogram CT scan revealed similar findings. The claimant was recommended by ___ to undergo surgery in January 2001 and April 2001. The claimant had a lot of other health issues including a cardiac problem for which he underwent coronary bypass surgery on 10/8/01. This was a quintuple bypass surgery. The claimant was finally cleared for low back surgery in January 2002, yet there continued to be some problems with his cardiac clearance. It was for this reason that ___ provided mostly palliative type treatment beginning in August 2002 until the claimant cold be cleared for surgery. Low back surgery was finally performed on 6/12/03 and seemed to consist of an L4/5

discectomy on the left. A post operative rehabilitation program was recommended as of 7/16/03 and the claimant technically began post operative physical therapy with the chiropractor on or about 8/1/03.

Requested Service(s)

The requested services include 97110, 99213, 97032, 97035, 97010, 97250, 97124, 98940, 99214, G0283 from 6/30/03 through 2/5/04.

Decision

I disagree with the carrier and find that the services rendered through 10/22/03 were medically necessary. I agree with the carrier and find that the services rendered from 10/24/03 onward through the end of the disputed dates of service were not medically necessary except for twice per month office visits billed at a 99213 or 99212 level beyond 10/24/03.

Rationale/Basis for Decision

It is my opinion that the documentation does not support the need for physician directed physical therapy in the post operative setting in this case beyond the 10/22/03 date. The exception would be routine office visits at approximately once every 2 weeks in order to continue to coordinate care and make referrals and this could have been done by ___ as he was the treating physician. The problems here are that the claimant's condition obviously started to plateau and quite honestly never really improved very much from the initiation of care. The claimant's condition seemed to plateau somewhere between 9/30/03 and 10/22/03. An exact plateau date is impossible to ascertain; however, it is clear that as of the 9/30/03 FCE the claimant was doing poorly. The 10/10/03 behavioral evaluation also revealed the claimant's pain levels to be a 9/10. The chiropractic documentation in the form of physical therapy follow up visits and other subsequent reports revealed that the claimant's condition essentially plateaued completely as of 10/22/03. It should also be mentioned that the 10/22/03 visit represented the 34th visit approximately from the 8/1/03 initiation of the post operative program. The highly evidence based Official Disability Guidelines recommend about 34 visits over a 16 week period for management in the post operative setting regarding lumbar fusion surgeries. This claimant did not undergo a lumbar fusion, in fact he underwent a less invasive microdiscectomy procedure without fusion. Therefore, the amount of care as of 10/22/03 was more than reasonable giving the benefit of the doubt to the claimant and the treating physician. In the presence of non-progression the treatment plan should have been changed beyond 10/22/03. It should also be mentioned that in early October 2003 the claimant was still complaining of a lot of left lower extremity problems in that even standing still was very painful. The small tiny improvements in lumbar range of motion and straight leg raise on the left from September to October 2003 were not enough to substantiate the quite extensive treatment rendered. Again, the claimant was certainly entitled to post operative treatment; however, it was made quite evident in the medical records that the claimant was not progressing very well even from the beginning. The lack of improvement certainly would not preclude the medical necessity of a post operative physical therapy program; however, as of 10/22/03 the claimant had more than enough therapy and was obviously not progressing. The claimant's age may have been a factor; however, there were no other barriers to improvement in my opinion beyond that of a normal post operative patient population. In fact the FCE of 9/30/03 revealed the claimant to be capable of medium to heavy duty work from a cardiovascular perspective even though the claimant was having great difficulty with some of the lift tasks. The point I am trying to make is that the claimant demonstrated cardiovascular health much greater than his physical health in that his previous cardiac history was not particularly a factor in his rehabilitation and would not substantiate the need for prolonged treatment. I certainly understand that the claimant was deconditioned; however, the amount of treatment far exceeded the highly evidence based Official Disability Guidelines for even a lumbar fusion surgery. I also noticed that there was not much change at all

in strength, objective findings or the amount of weight lifted during the rehabilitation beyond the FCE of 9/30/03 and especially beyond 10/22/03. I certainly understand that the claimant was not going to be able to return to his heavy duty truck driving responsibilities; however, sufficient treatment given that particular treatment plan at the time through 10/22/03 should have provided a reasonable amount of condition such that the claimant could have been introduced to a chronic pain management program and possibly vocational retraining. The highly evidence based Official Disability Guidelines also recommend a return to work at light to moderate manual duty work at 56 days following discectomy surgery in the low back. A return to work could be indefinite at the heavy duty level; however, the claimant should have been able to retain some light duty work especially since he was receiving rehabilitation at approximately 56 days post surgery. The bottom line is that although post operative treatment was certainly medically necessary, the amount of treatment far exceeded the evidence based guidelines and beyond 10/22/03 or perhaps as early as 9/30/03 was not deemed to be effective.