

MDR Tracking Number: M5-04-3560-01

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, 133.307 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 06-21-04.

The IRO reviewed therapeutic exercises, EMS, myofascial release, joint mobilization, neuromuscular re-education, mechanical traction and office visits rendered from 07-10-03 through 07-23-03 that were denied based upon "V".

The IRO determined that the office visits rendered on 07-16-03 and 07-18-03 **were not** medically necessary. The IRO determined that the remaining services (therapeutic exercises, EMS, myofascial release, joint mobilization, neuromuscular re-education and mechanical traction) **were** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. 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.

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. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-06-04, 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.

CPT code 99213-MP date of service 07-21-03 denied with denial code "D" (duplicate). Per Rule 133.304(c) the carrier did not specify which service CPT code 99213-MP was a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$48.00.

CPT code 97110 date of service 07-21-03 denied with denial code "D" (duplicate). 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

CPT code 97112 date of service 07-21-03 denied with denial code "D" (duplicate). Per Rule 133.304(c) the carrier did not specify which service CPT code 99213-MP was a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$35.00.

CPT code 97250 date of service 07-21-03 denied with denial code "D" (duplicate). Per Rule 133.304(c) the carrier did not specify which service CPT code 99213-MP was a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$43.00.

CPT code 97265 date of service 07-21-03 denied with denial code "D" (duplicate). Per Rule 133.304(c) the carrier did not specify which service CPT code 99213-MP was a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$43.00.

CPT code 99080 date of service 01-21-04 is listed on the table of disputed services. No HCFA was submitted by the requestor. Per Rule 133.304(k)(1)(A) no reimbursement is recommended.

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) 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 07-10-03 through 07-23-03 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 Findings and Decision and Order are hereby issued this 17th day of December 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

SECOND AMENDED DECISION

Date: November 2, 2004

RE:

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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:

- Exercise notes with instructions for dates of services 07/07/2003 – 07/23/2003

Submitted by Respondent:

- E1
- Peer review by _____
- Requests for reconsideration letters
- Exercise notes
- X-ray report
- TWCC 73 reports.

Clinical History

According to the supplied documentation, it appears that the claimant sustained an injury to his low back after lifting a machine at work on _____. The claimant was first seen by _____ on 05/21/2003. The claimant was evaluated and treated at _____ on 05/22/2003. The claimant was returned to work with restrictions. Plain film x-rays performed on 06/03/2003 revealed an annular cleft at L1-2, minimal dextro-thoracolumbar curvature with right rotation and inferiority of right femoral head. The claimant was treated with passive and active modalities. The claimant was released to full duty on 07/03/2003. The documentation ends on 07/23/2003.

Requested Service(s)

Please review and address the medical necessity of the services rendered including therapeutic exercises, EMS, myofascial release, joint mobilization, neuromuscular re-education, mechanical traction and office visits dated 07/10/2003 – 07/23/2003.

Decision

I agree with the insurance carrier that the office visits rendered on 07/16/2003 and 07/18/2003 were not medically necessary. I disagree with the carrier and agree with the treating provider that the remainder of the services were medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, it appears the claimant sustained a lifting injury on _____. The claimant was diagnosed with a sprain of the lumbosacral joint. The claimant underwent passive modalities with a transition to an active protocol. The claimant was treated from 05/22/2003 – 07/23/2003 which is approximately 8 weeks and falls well within current chiropractic and medical protocols. No evidence of over treatment was reviewed. Office visits that occurred on every date of service (07/16/2003 and 07/18/2003) are not seen as necessary. Since the claimant was being seen on a regular basis, then proper documentation would objectively monitor the claimant's

improvement. The office visit dated 07/23/2003 was seen as reasonable, since it was the last date of service rendered.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 2nd day of November 2004.