

MDR Tracking Number: M5-04-3608-01

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. The dispute was received on 06-24-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of 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** 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. The therapeutic exercises from 8-1-03 through 10-30-03 and the office visits on 8-1-03, 8-7-03, 8-20-03, 8-27-03, 9-4-03, 9-13-03, 9-27-03, 10-4-03, 10-11-03, and 10-28-03 **were found** to be medically necessary. The manual therapy and neuromuscular reeducation from 8-1-03 through 10-30-03 and the office visits on 8-2-03, 8-4-03, 8-8-03, 8-23-03, 8-25-03, 8-29-03, 9-2-03, 9-6-03, 9-10-03, 9-15-03, 9-17-03, 9-23-03, 9-26-03, 9-30-03, 10-8-03, 10-10-03, 10-14-03, 10-16-03, and 10-30-03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On 9-1-04 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.

No Explanation of Benefits were submitted for CPT Code 97110 billed on dates of service 8-27-03, and 8-29-03. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings 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.

No Explanation of Benefits were submitted for CPT Code 97140 billed on dates of service 8-27-03, and 8-29-03. Therefore, this review will be per the Trailblazer Online Fee Schedule. Relevant information supports delivery of service. Recommended reimbursement of \$67.80 + \$67.80=\$135.60.

No Explanation of Benefits were submitted for CPT Code 97112 billed on dates of service 8-27-03, and 8-29-03. Therefore, this review will be per the Trailblazer Online Fee Schedule. Relevant information supports delivery of service. Recommended reimbursement of \$36.69 + \$36.69=\$73.38.

This Findings and Decision is hereby issued this 21st day of September 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

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 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 Order is applicable to dates of service 8-1-03 through 10-3-03 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 21st day of September, 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/da

NOTICE OF INDEPENDENT REVIEW DECISION

August 27, 2004

Rosalinda Lopez
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 #: M5-04-3608-01
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 Rule §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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional 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 37 year-old male injured his low back on ___ when he lifted a large metal panel while constructing a metal building. He felt an immediate and severe onset of sharp low back pain. He has been diagnosed with inferiorly extruded right paracentral protrusion at L5-S1 deforming the right S1 nerve root sleeve and broad-based disc protrusion flattening both L5 nerve root sleeves, right lumbar radiculopathy and large right-sided herniated nucleus pulposus at L5-S1. He has been treated with therapy, epidural steroid injections and medications.

Requested Service(s)

Office visits, therapeutic exercises, manual therapy and neuromuscular reeducation for dates of service 08/01/03 through 08/25/03, 08/27/03, 08/29/03 (office visit only), and 09/02/03 through 10/30/03.

Decision

It is determined that the therapeutic exercises from 08/01/03 through 10/30/03 and the office visits on 08/01/03, 08/07/03, 08/20/03, 08/27/03, 09/04/03, 09/13/03, 09/20/03, 09/27/03, 10/04/03, 10/11/03, and 10/28/03 were medically necessary to treat the patient's medical condition.

However, the manual therapy and neuromuscular reeducation from 08/01/03 through 10/30/03 and the office visits on 08/02/03, 08/04/03, 08/08/03, 08/23/03, 08/25/03, 08/29/03, 09/02/03, 09/06/03, 09/10/03, 09/15/03, 09/17/03, 09/23/03, 09/26/03, 09/30/03, 10/08/03, 10/10/03, 10/14/03, 10/16/03, and 10/30/03 were not medically necessary to treat the patient's medical condition.

Rationale/Basis for Decision

Medical records indicate that this patient was in an established physical therapy program by 08/01/03 and there is no documentation to demonstrate medical necessity for assessments on more than a weekly basis. Therefore, weekly office visits were medically necessary, but all office visits in excess of 1 visit weekly were not medically necessary.

The use of therapeutic exercises from 08/01/03 to 10/30/03 was medically necessary. The Philadelphia Panel found that therapeutic exercises were found to be beneficial for chronic, subacute, and post-surgery low back pain.

The use of manual therapy and neuromuscular reeducation from 08/01/03 through 10/30/03 was not medically necessary. The progress notes revealed no lasting benefits from the chiropractic treatments and the records revealed no evidence of a neuromuscular deficit that would necessitate the use of neuromuscular reeducation. Neuromuscular reeducation is commonly utilized for post-stroke rehabilitation and is not commonly utilized for the management of conditions similar to the claimant's. The Common Procedural Terminology Code Book defines neuromuscular reeducation as: "*reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception*". The progress notes for the claimant's office visits do not provide medical necessity for the use of this procedure at each office visit, as no evidence of a neurological deficit leading to a breakdown in the neural link between the locomotor cortex of the brain and the musculoskeletal system was identified in the records as affecting the patient. Therefore, the manual therapy and neuromuscular reeducation was not medically necessary to treat this patient's medical condition.

Sincerely,