

MDR Tracking Number: M5-04-3660-01

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 06-29-04.

The IRO reviewed therapeutic exercises, manual therapy technique, neuromuscular re-education and chiropractic manipulation rendered from 12-10-03 through 03-16-04 that were denied based upon "U".

The IRO determined that therapeutic exercises, manual therapy technique, neuromuscular re-education and chiropractic manipulation through 02-03-04 **were** medically necessary and therapeutic exercises, manual therapy technique, neuromuscular re-education and chiropractic manipulation after 02-03-04 **were not** medically necessary. The respondent raised no other reasons for denying the above listed services.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 07-27-04, 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 **98941** for dates of service 12-10-03 through 01-28-04 (16 dates of service) with denial code Y, JM (code and/or modifier is invalid). Code 98941 is the proper CMS code per the Medical Fee Guideline effective 08-01-03. Per Rule 134.202(b)(c)(1) reimbursement is recommended in the amount of **\$731.84** ( $\$36.59 \times 125\% = \$45.74$  for dates of service 2003 and  $\$37.19 \times 125\% = \$46.49$  for dates of service 2004). The requestor only billed for and disputed  $\$45.74$  per date of service therefore  $\$45.74$  for the 2004 dates of service is the recommended reimbursement as well as the 2003 dates of service.

CPT code **99080** date of service 12-09-03 denied with denial code "F/86" (provider billed for work status report on a subsequent date of service). The requestor did not submit relevant information to support delivery of service. No reimbursement recommended.

Review of requestor's and respondent's documentation for CPT code **99080** date of service 12-23-03 revealed that neither party submitted a copy of the EOB. Proof of submission was reflected by review of the reconsideration HCFA and copy of submission to the respondent via certified mail. Per the Medical Fee Guideline effective 08-01-03 reimbursement in the amount of **\$70.00** is recommended.

CPT code **97112** dates of service 01-12-04, 01-13-04, 01-14-04, 01-20-04 and 01-22-04 denied with denial code G/Z3 (component code is considered integral to the comprehensive procedure/the procedure does not represent a separately identifiable, unrelated procedure). The carrier did not specify which service code 97112 is global to. The services will be reviewed according to the Medical Fee Guideline effective 08-01-03. Reimbursement per the MFG effective 08-01-03 is  $\$185.25$  ( $\$29.64 \times 125\% = \$37.05 \times 5$  DOS). However, the requestor only billed for and disputed  $\$36.94$  per date of service. Reimbursement is recommended in the amount of **\$184.70** ( $\$36.94 \times 5$  DOS).

CPT code **97110** date of service 01-19-04 denied with denial code "F" (reduced or denied in accordance with the appropriate fee guideline and/or MAR). See the rationale below for this code.

Review of the requestor's and respondent's documentation revealed that neither party submitted a copy of the EOB for CPT code **97110** date of service 01-26-04. See the rationale below for this code.

CPT code **97140-50** date of service 01-19-04 and 01-20-04 denied with denial code "G" (global). The carrier was not specific in the denial as to which code 97140-50 was global to, the service will therefore be reviewed according to the Medical Fee Guideline effective 08-01-03. The MFG effective 08-01-03 reimbursement is \$68.26 ( $\$27.30 \times 125\% = \$34.13 \times 2 \text{ units} = \$68.26$ ). The requestor only billed and disputed \$68.10 so reimbursement in the amount of **\$136.20** ( $\$68.10 \times 2 \text{ DOS}$ ) is recommended.

Review of requestor's and respondent's documentation for CPT code **97140-59** date of service 01-26-04 revealed that neither party submitted a copy of the EOB. Proof of submission was reflected by review of the reconsideration HCFA and copy of submission to the respondent via certified mail. Reimbursement per the Medical Fee Guideline effective 08-01-03 is \$68.26 ( $\$27.30 \times 125\% = \$34.13 \times 2 \text{ units}$ ). The requestor only billed and disputed \$68.10 therefore reimbursement in the amount of **\$68.10** is recommended.

Review of requestor's and respondent's documentation for CPT code **97112** date of service 01-26-04 revealed that neither party submitted a copy of the EOB. Proof of submission was reflected by review of the reconsideration HCFA and copy of submission to the respondent via certified mail. Reimbursement per the Medical Fee Guideline effective 08-01-03 is \$37.05 ( $\$29.64 \times 125\%$ ). The requestor only billed and disputed \$36.94 therefore reimbursement in the amount of **\$36.94** is recommended.

**RATIONALE 97110:** 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 (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

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

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division  
DLH/dlh

### 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 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 Decision is applicable for dates of service 12-10-03 through 02-03-04 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 14<sup>th</sup> day of October 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division  
RL/dlh

## NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION

**Date:** September 17, 2004

**RE:**

**MDR Tracking #:** M5-04-3660-01

**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:**

- Correspondence Letter dated 9/6/04 from \_\_\_\_\_
- TWCC 60 dated 7/2/04
- Table of Disputed Services dates 12/10/03-3/16/04
- Explanation of Benefits from \_\_\_\_\_ dates 12/9/03-3/18/04
- Order of Payment for Independent Review Organization Fee
- Initial Report dated 12/9/03 from \_\_\_\_\_
- Treatment Plan dated 12/23/03 from \_\_\_\_\_
- MRI of the Lumbar Spine dated 1/23/04 from \_\_\_\_\_
- Electrodiagnostic Study Report dated 3/4/04 from \_\_\_\_\_
  
- TWCC 69 dated 3/4/04 from \_\_\_\_\_
- IME Report dated 7/8/04 from \_\_\_\_\_
- Designated Doctors Evaluation Report dated 6/28/04 from \_\_\_\_\_
- Electrophysiological Study of the Lower Extremity dated 4/20/04 from \_\_\_\_\_
- Physical Performance Test dates 1/8/04, 4/6/04, 5/20/04, and 6/10/04
- Daily Notes from \_\_\_\_\_ dates 12/10/03-3/18/04
- Therapeutic Exercise Weekly Record dates 12/9/03-3/18/04

**Submitted by Respondent:**

- None submitted

## **Clinical History**

The claimant injured his low back \_\_\_\_ while lifting sheet rock at work for \_\_\_\_\_. The claimant initially sought care at \_\_\_\_\_ with \_\_\_\_\_ whose treatment plan consisted of Chiropractic Manipulation, Joint Mobilization, Myofascial therapy, Lumbar Traction, Rehabilitative Exercises and Neuromuscular Re-Education. The claimant had a MRI of the lumbar spine performed on 1/23/04 from \_\_\_\_\_ which revealed a L5/S1 mild to moderate diffuse posterior disc protrusion (8mm). This does not result in spinal stenosis or neural impingement. There are associated degenerative disc changes present. The claimant also had electrodiagnostic studies of the lower extremity performed on 3/4/04 from \_\_\_\_\_, which revealed evidence a right L2/L3 lumbar radiculopathy. The claimant was evaluated by a doctor selected by the treating doctor \_\_\_\_\_ on 7/8/04 who determined the claimant at MMI of 7/8/04 with a 10% whole person impairment. The claimant was also evaluated by designated doctor \_\_\_\_\_ on 6/28/04, who determined the claimant was not at MMI with an anticipated date of MMI on 9/17/04. The claimant had approximately 41 chiropractic treatment visits from 12/10/03-3/18/04 and participated in a work hardening program. The claimants last Physical Performance Test on 7/1/04 revealed the claimant was capable of returning to work at full duty.

## **Requested Service(s)**

Therapeutic exercises (97110), Manual therapy technique (97140-59), Neuromuscular re-education (97112), Chiropractic manipulation (98941) from 12/10/03-3/16/04.

## **Decision**

I disagree with the insurance carrier and find that therapeutic exercises (97110), manual therapy technique (97140-59), neuromuscular re-education (97112), and chiropractic manipulation (98941) are reasonable and necessary for the claimant for a period of 18 chiropractic treatments over a 6-8 week period, up to 2/3/04.

I agree with the insurance carrier and find that therapeutic exercises (97110), manual therapy technique (97140-59), neuromuscular re-education (97112), and chiropractic manipulation (98941) are not reasonable and necessary after 2/3/04

## **Rationale/Basis for Decision**

I form my decision using the Official Disability Guidelines 8th Edition which allows a total of up to 18 chiropractic treatments over a 6-8 week period for lumbar intervertebral disc without myelopathy (722.10) with evidence of functional improvement, the doctor should help avoid chronicity and gradually fade the claimant into active self-directed care. Based on this information it would seem

medically reasonable and necessary for the claimant to have the disputed treatments for no longer than 6-8 weeks or 2/3/04. It would have seemed reasonable for the claimant to have been referred for co-management with medications to help speed recovery after four weeks of initial (trial) care. The Official Disability Guideline 8th Edition is a guideline of specific conditions which uses a major source being the "Mercy Guidelines", the consensus document created by the American Chiropractic Association in conjunction with the Congress of State Chiropractic Associations,

entitled Guidelines for Chiropractic Quality Assurance and Practice Parameters, Proceedings of the Mercy Center Consensus Conference. It from these Guidelines I form my decision for the above reference claimant.

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 17<sup>th</sup> day of September 2004.