

MDR Tracking Number: M5-04-4010-01

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 (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 7-23-04.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 7-1-03 through 7-21-03.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

The office visits, electrical stimulation, myofascial release and hot-cold pack therapy from 7-23-03 through 7-30-03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 8-17-04, the Medical Review Division submitted a Notice to the 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 99212 for dates of service 8-1-03, 8-4-03, 8-6-03, 8-7-03, 8-12-03, 8-13-03, 8-15-03, 8-18-03 and 8-19-03 was billed by the requestor and denied by the carrier. Neither party submitted EOB's for these dates of services and did not timely respond to the request for additional information. The requester provided convincing evidence of carrier receipt of the provider's request for EOBs in accordance with Rule 133.307(e)(2)(B). Therefore, these dates of service will be reviewed in accordance with Rule 134.202. The carrier did not provide a valid basis **for the denial of** this service. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge). **Reimbursement is recommended in the amount of \$377.19. (\$41.91 x 9 dos)**

CPT code 97032 for dates of service 8-1-03 was billed by the requestor and denied by the carrier. Neither party submitted EOB's for these dates of services and did not timely respond to the request for additional information. The requester provided convincing evidence of carrier receipt of the provider's request for EOBs in accordance with Rule 133.307(e)(2)(B). Therefore, these dates of service will be reviewed in accordance with Rule 134.202. The carrier did not provide a valid basis for the denial of this service. **Reimbursement is recommended in the amount of \$18.83. (\$18.83 x 1 dos)**

CPT code 97035 for dates of service 8-1-03 (2 units), 8-4-03, 8-6-03, 8-7-03 (2 units), 8-12-03 (2 units), 8-13-03 (2 units), 8-15-03 (2 units), 8-18-03 (2 units) and 8-19-03 was billed by the requestor and denied by the carrier. Neither party submitted EOB's for these dates of services and did not timely respond to the request for additional information. The requester provided convincing evidence of carrier receipt of the provider's request for EOBs in accordance with Rule 133.307(e)(2)(B). Therefore, these dates of service will be reviewed in accordance with Rule 134.202. The carrier did not provide a valid basis for the denial of this service.

Reimbursement is recommended in the amount of \$170.55). (\$11.37 x 15 units)

CPT code 97140 for dates of service 8-1-03 (2 units), 8-4-03 (2 units), 8-6-03 (2 units), 8-7-03 (2 units), 8-12-03 (2 units), 8-13-03 (2 units), 8-15-03 (2 units), 8-18-03 (2 units) and 8-19-03 (2 units) was billed by the requestor and denied by the carrier. Neither party submitted EOB's for these dates of services and did not timely respond to the request for additional information. The requester provided convincing evidence of carrier receipt of the provider's request for EOBs in accordance with Rule 133.307(e)(2)(B). Therefore, these dates of service will be reviewed in accordance with Rule 134.202. The carrier did not provide a valid basis for the denial of this service. **Reimbursement is recommended in the amount of \$556.20. (30.90 x 18 units)**

Regarding CPT code 97110 for dates of service 8-4-03, 8-6-03, 8-7-03, 8-12-03, 8-13-03, 8-15-03, 8-18-03 and 8-19-03: 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.**

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 Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202(c); in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c)(6); 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 8-1-03 through 8-19-03 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 Decision and Order is hereby issued this 5th day of November, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

September 23, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-4010-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ----- external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ----- chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 42 year-old male who sustained a work related injury on ----- . The patient reported that while at work he injured his low back. The patient was evaluated and prescribed medications. X-rays taken that day were reported to be normal. The patient began treatment of electrical muscle stimulation, moist heat and manual massage. On 5/20/03 the patient underwent a MRI of the lumbar spine that indicated a disc desiccation at L4-5 and right posterolateral disc protrusion at L5-S1. On 8/5/03 the patient underwent lumbar epidural steroid injection with fluoroscopic needle placement technique for the diagnosis of lumbosacral radiculitis. The patient continued with conservative care consisting of moist heat, electrical stimulation and myofascial release.

Requested Services

Office visit 99213, electrical stimulation 97014, myofascial release 97250, and hot/cold pack therapy 97010 from 7/23/03 – 7/30/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Initial Report (no date)
2. MRI report 5/20/03
3. Orthopedic evaluation 6/5/03, 7/1/03
4. Treatment notes 6/19/03 – 8/1/03
5. Operative Report 8/5/03
6. Progress Report 7/18/03, 8/18/03
7. Daily SOAP notes 8/1/03 – 8/19/03

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a 42 year-old male who sustained a work related injury to his low back on ----- . The ----- chiropractor reviewer indicated that the initial phase of care is 0-8 weeks for low back pain (American Association of Orthopedic Surgeons and the National Spine Society Guidelines). The ----- chiropractor reviewer explained that if a patient's symptoms are unresolved after 8 weeks, then treatment modification and additional active exercises should be performed. The ----- chiropractor reviewer noted that the medical records provided from 7/23/03 – 7/30/03 indicated that the patient's pain level remained a 9/10 and was experiencing muscle spasms in the thoracic and lumbar regions. The ----- chiropractor reviewer explained that without treatment modifications or addition of active exercises, treatment for dates of service 7/23/03 – 7/30/03 were not medically necessary. Therefore, the ----- chiropractor consultant concluded that the Office visit 99213, electrical stimulation 97014, myofascial release 97250, and hot/cold pack therapy 97010 from 7/23/03 – 7/30/03 were not medically necessary to treat this patient's condition.

Sincerely,