

MDR Tracking Number: M5-04-4069-01

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 7-29-04.

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.

The unlisted therapeutic procedures, manual therapy technique, therapeutic procedure, mechanical traction and office visits from 8-6-03 through 11-12-03 were **found** to be medically necessary. The unlisted therapeutic procedures, manual therapy technique, therapeutic procedure, mechanical traction and office visits from 11-25-03 through 2-11-04 **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 issues were not the only issues 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 8-24-04 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 97750-MT for date of service 8-4-03 (2 units) – reimbursement is included in the basic allowance for another procedure. Per rule 133.304 (c) Carrier didn't specify which service this was global to. **Recommend reimbursement of \$73.38.**

CPT code 97139 for date of service 8-4-03 was denied with an MU - Physical medicine and rehab services may not be reported in conjunction with an evaluation and management code performed on the same day. The Texas Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries LCD states: "For all claims submitted with an unlisted procedure code, a complete narrative description (detailing the service or procedure being performed) and the treatment plan must be submitted with the claims." No additional documentation was submitted supporting these services. **Recommend no reimbursement.**

CPT code 97140 for date of service 8-4-03 was denied with an MU - Physical medicine and rehab services may not be reported in conjunction with an evaluation and management code performed on the same day. The Texas Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries LCD states: "When both a modality/procedure and an evaluation service are billed, the evaluation may be reimbursed if the medical necessity for the evaluation is clearly documented. Standard medical practice may be one or two visits in addition to physical therapy treatments. Reimbursement beyond this standard utilization requires documentation supporting the medical necessity for the office visit. No additional documentation was submitted supporting these services. An office visit on this date was reimbursed by the Carrier. **Recommend no reimbursement.**

CPT code 97012 for date of service 8-4-03 was denied with an MU - Physical medicine and rehab services may not be reported in conjunction with an evaluation and management code performed on the

same day. The Texas Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries LCD states: "Modality code 97012 requires supervision by the provider." A review of the file show that there is no documentation supporting supervision by the provider. **Recommend no reimbursement.**

CPT code 99213 for date of service 8-6-03, 8-11-03, 8-20-03, 8-21-03, 8-22-03, 8-29-03, 9-3-03, was denied with an MU - Physical medicine and rehab services may not be reported in conjunction with an evaluation and management code performed on the same day. The Texas Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries LCD states: "When both a modality/procedure and an evaluation service are billed, the evaluation may be reimbursed if the medical necessity for the evaluation is clearly documented. Standard medical practice may be one or two visits in addition to physical therapy treatments. Reimbursement beyond this standard utilization requires documentation supporting the medical necessity for the office visit." No additional documentation was submitted supporting these services. **Recommend no reimbursement.**

CPT code 97139 for date of service 8-22-03 was denied with an "NC" – A service has been billed for which a payment is not allowed under the fee schedule. The service is either not covered or the service is not recognized as a valid service. Trailblazer does verify that this is a "covered" "Valid" service. **Recommend reimbursement of \$20.19.**

CPT code 97140 for date of service 8-22-03 was denied with an "NC" – A service has been billed for which a payment is not allowed under the fee schedule. The service is either not covered or the service is not recognized as a valid service. Trailblazer does verify that this is a "covered" "Valid" service. **Recommend reimbursement of \$33.90.**

CPT code 97012 for date of service 8-22-03, 8-29-03, 9-3-03 was denied with an "NC" – A service has been billed for which a payment is not allowed under the fee schedule. The service is either not covered or the service is not recognized as a valid service. Trailblazer does verify that this is a "covered" "Valid" service. **Recommend reimbursement of \$56.49.**

CPT code 99080-73 for date of service 10-3-03, 11-11-03, 12-10-03 was denied as F – the work status report was not properly completed. However, no specific information was given as to the information lacking in the report. The requestor submitted this report to the Commission. **Recommend reimbursement of \$45.00.**

CPT code 99214 for date of service 10-03-03 was denied with an F – the procedure billed exceeds the level of service required by the diagnosis given. The requestor submitted no additional documentation to support this level of service. **No reimbursement recommended.**

CPT code 97139 for date of service 10-17-03 was denied with a Y, UL. The Texas Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries LCD states: "For all claims submitted with an unlisted procedure code, a complete narrative description (detailing the service or procedure being performed) and the treatment plan must be submitted with the claims." No additional documentation was submitted supporting these services. **Recommend no reimbursement.**

This Findings and Decision is hereby issued this 26th day of January, 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

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) and 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.

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 26th day of January, 2005.

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

NOTICE OF INDEPENDENT REVIEW DECISION

SECOND AMENDED DECISION

Original Date: September 23, 2004

1st Amend Date: September 28, 2004

2nd Amend Date: January 19, 2005

To The Attention Of: Rosalinda Lopez
 TWCC
 7551 Metro Center Drive, Suite 100, MS-48
 Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-04-4069-01
IRO Certificate #: 5242

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

Forté 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:

- Table of Disputed Services dates 8/4/03-2/11/04
- Request for Reconsideration Letter dated 6/25/04 from Dr. R, D.C.
- TWCC 73 from Dr. G, D.C. dates 8/4/03,9/4/03,10/3/03, 11/11/03, 12/10/03, 1/14/04, 3/10/04
- MRI of the Lumbar Spine from Steeplechase Diagnostic & Open MRI dated 10/16/02
- Orthopedic Evaluation dated 10/24/02 from Dr. Y, M.D.
- Evaluation Report dated 10/30/02 from Dr. P, M.D.
- Follow up Reports from Dr. P, M.D. dates 11/2/02, 11/27/02, 12/18/02, 1/22/03, 12/10/03, 1/14/03,2/11/04 and 5/5/04
- Operative Report from Dr. P, M.D. dates 11/21/02, 1/23/03, 1/30/03, 12/4/03 and 2/19/04
- EMG/NCV of the Lower Extremity dated 12/13/02 from Dr. W, M.D.
- Orthopedic Follow-up Evaluations from Dr. Y, M.D. dates 1/16/03, 2/13/03, 3/18/03, 5/8/03, 6/12/03, 8/26/03, 9/17/03, 10/22/03, 11/25/03, 1/20/04, 2/18/04, 3/25/04, 4/27/04 and 6/10/04
- Lumbar myelogram dated 3/7/03 from Steeplechase Diagnostics and Open MRI
- FCE/PPT dated 3/26/03 from Dr. L, D.C.
- IME Report dated 4/8/03 from Dr. D, M.D.
- Operative Report from dated 7/14/03 Dr. Y, M.D.
- Post Surgical Medical Report dated 8/4/03 from Synergy Chiropractic & Wellness Care
- Evaluation Report from Northwest Houston Pain Care Center, LLC. Dated 9/12/03
- Report of Medical Evaluation dated 10/3/03 from Synergy Chiropractic & Wellness Care
- MRI of the Lumbar Spine dated 10/10/03 from Champion Open MRI
- Subsequent Medical Report dated 12/10/03 Synergy Chiropractic & Wellness Care
- Re-Evaluation Report dated 1/14/04 from Synergy Chiropractic & Wellness Care
- Discharge Summary dated 1/15/04 from Pain and Rehab of the Southwest
- Post-Myelographic CT Scan of the Lumbar Spine dated 3/16/04 from Gulf Coast Diagnostics
- Designated Doctor Evaluation dated 5/27/04 from Dr. E, M.D.
- EMG/NCV Report dated 6/3/04 from Dr. A, M.D.

Submitted by Respondent:

- Table of Disputed Services dates 8/4/03-2/11/04
- Explanation of Benefits dates 8/6/03-2/11/04 from Texas Mutual Insurance Company

Clinical History:

I have had the opportunity to review the medical records in the above-mentioned case for the purpose of an Independent Review. ___ injured his low back ___ while lifting a box of paintings while at work for ___. The claimant initially sought care at Synergy Chiropractic and Wellness Care from Dr. G, D.C. The claimant continued to complain of lower back pain with radicular symptoms and was referred for an MRI of the lumbar spine. The MRI of the lumbar spine which was performed on 10/10/03 revealed at L5/S1 disc shows degenerative changes and narrowing with a broad based left posterolateral and partly intraforaminal focal protrusion (herniation) contacting the S1 root. Mild facet arthropathy is also seen at this level. The claimant was referred for an orthopedic evaluation with Dr. Y, M.D. who recommended the claimant have lumbar epidural steroid injection (ESI) prior to considering surgical intervention. The lumbar ESI's were performed by Dr. P, M.D. 11/21/02, 1/23/03 and 1/30/03. The claimant received temporary relief of symptoms from these procedures, however the symptoms of low back and radicular pain continued to persist and the claimant subsequently required surgical intervention on 7/14/03 from Dr. Y who performed a discectomy at L5/S1, neural foraminectomy, and left L5/S1 laminectomy. The claimant participated in a post-operative physical therapy program with Dr. G. The claimant was evaluated by designated doctor Dr. L, M.D. on 5/27/04 and determined the claimant at maximum medical improvement with a 5% whole person impairment. The claimant continues to complain of low back pain with radicular symptoms and continues to see Dr. Y who is awaiting approval for lumbar discogram.

Requested Service(s)

Unlisted therapeutic procedures (97139), manual therapy technique (97140), therapeutic procedure (97110), mechanical traction (97012), and office visits regarding the above mentioned injured worker for dates of service 8/6/03-2/11/04.

Decision

I disagree with the insurance carrier and find that unlisted therapeutic procedures (97139), manual therapy technique (97140), therapeutic procedure (97110), mechanical traction (97012), and office visits regarding the above mentioned injured worker are reasonable and necessary for the claimant for a period of 32 physical therapy visits over a 16 week period for post surgical physical therapy for the lumbar spine.

I agree with the insurance carrier and find that unlisted therapeutic procedures (97139), manual therapy technique (97140), therapeutic procedure (97110), mechanical traction (97012), and office visits regarding the above mentioned injured worker are not reasonable and necessary after 11/24/03 and further treatment beyond this time frame could be consider excessive.

Rationale/Basis for Decision

I disagree with the insurance carrier and find that unlisted therapeutic procedures (97139), manual therapy technique (97140), therapeutic procedure (97110), mechanical traction (97012),

and office visits regarding the above mentioned injured worker are reasonable and necessary for the claimant for a period of 32 physical therapy visits over a 16 week period for post surgical physical therapy for the lumbar spine. I form my decision using the Official Disability Guidelines 8th Edition which allows a total of up 32 physical therapy treatment over a 16 week period with gradually fading 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 16 weeks or 11/24/03.

I agree with the insurance carrier and find that unlisted therapeutic procedures (97139), manual therapy technique (97140), therapeutic procedure (97110), mechanical traction (97012), and office visits regarding the above mentioned injured worker are not reasonable and necessary after 11/24/03 and further treatment beyond this time frame could be consider excessive. I form this decision using the Official Disability Guidelines 8th Edition which allows up to 32 physical therapy treatment over 16 weeks for post surgical lumbar intervertebral disc. 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 would seem reasonable for the claimant to follow-up with the treating doctor Dr. G, D.C. 1-2 times monthly for evaluation of progress of symptoms with home treatment.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 19th day of January 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: