

MDR Tracking Number: M5-04-4116-01

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 08/02/04.

The IRO reviewed office visits (99213, 99214), therapeutic exercises (97110), manual therapy technique (97140) and the unlisted therapy procedures (97139) rendered from 10/09/03 through 01/07/04 that was denied based upon "V".

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.

The office visits and therapeutic exercises for dates of service 10/09/03 through 01/07/04 **were** found to be medically necessary. The manual therapy, unlisted therapy procedures for date of service 10/09/03 through 01/07/04 **were not** found to be medical necessary. The respondent raised no other reasons for denying reimbursement for the office visits (99213, 99214), therapeutic exercises (97110), manual therapy technique (97140) and the unlisted therapy procedures (97139).

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision. The carrier did not respond to the TWCC-60 in a timely manner.

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 August 27, 2004, 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 99080-73 for dates of service 10/09/03, denied as "F", 11/11/03, EOB not submitted by either party, 12/12/03 denied as "U", and 01/26/04, denied for "V". Work Status Reports are a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Per Commission Rule 134.1(c) and 133.106(f)(1) reimbursement in the amount of \$60.00 is recommended.
- CPT Code 97110 (8 units total), for dates of service 11/06/03 and 11/21/03. 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 of the Commission requirements for proper documentation. The MRD declines to order payment as the requestor did not submit relevant information that clearly delineates 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.
- CPT Code 97139 (9 units total) for dates of service 11/03/03 through 11/11/03, 11/21/03, and 12/12/03 through 01/07/04 denied as "F". Per Commission Rule 134.202(b) and (c)(1) reimbursement in the amount of \$181.71 ($\$16.15 \times 125\% = \20.19×9) is recommended.
- CPT Code 97140 (16 units total) for dates of service 11/03/03 through 11/11/03, 11/21/03, and 12/12/03 through 01/07/04 denied as "F". Per Commission Rule 134.202(b) and (c)(1) reimbursement in the amount of \$542.56 ($\$27.12 \times 125\% = \33.91×16) is recommended.
- CPT Code 99213 for dates of service 11/21/03 and 12/22/03 denied as "F". Per Commission Rule 134.202(b) and (c)(1) reimbursement in the amount of \$130.42 ($\$52.17 \times 125\% = \65.21×2) is recommended.

- CPT Code 99215 for date of service 01/26/04. Neither the requestor nor the respondents submitted EOB's. These dates of service will be reviewed in accordance with Rule 134.202(b) and (c)(1) effective 08/01/03. Since the carrier did not provide a valid basis for the denial of this service, reimbursement in the amount of \$149.36 is recommended. The Medicare Fee Schedule amount times 125% = \$152.15; however the requestor listed the recommended payment amount as the amount in dispute.

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 10/09/03 through 11/21/03 and 12/12/03 through 01/26/04 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 Decision and Order is hereby issued this 8th day October 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

September 30, 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 #: M5-04-4116-01
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 45 year-old female injured her neck and left upper extremity on ____ when she slipped in the restroom due to standing water on the floor. She fell and hit her left upper extremity and neck on the counter top. Her diagnosis is cervical pain of discogenic origin. She has been treated with therapy, epidural steroid injections, medications and surgery.

Requested Service(s)

Office visits, therapeutic exercises, unlisted therapy procedures, and manual therapy technique for dates of service 10/09/03 through 01/07/04

Decision

It is determined that the manual therapy technique and the unlisted therapy procedures were not medically necessary for the dates of service 10/09/03/ through 01/07/04. However, the office visits and therapeutic exercises were medically necessary to treat this patient's medical condition for the dates of service 10/09/03 through 01/07/04.

Rationale/Basis for Decision

Medical record documentation does not indicate the necessity for manual therapy technique and the unlisted therapy procedures. An adequate trial of manual therapy care is defined as a course of two weeks each of different types of manual procedures (4 weeks total), after which, in the absence of documented improvement, manual procedures are no longer indicated. The patient showed a lack of response to manual therapy technique treatments and fell outside the 4-week treatment window, as treatments began in May of 2003.

The office visits and therapeutic exercises were medically necessary to manage and treat the patient's medical condition. According to the *Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Neck Pain*, therapeutic exercises were the only intervention with clinically important benefit. For several interventions and indications (e.g., thermotherapy, therapeutic ultrasound, massage, electrical stimulation), there was a lack of evidence regarding efficacy. Therefore, the manual therapy technique and the unlisted therapy procedures were not medically necessary for the dates of service 10/09/03/ through 01/07/04. However, the office visits and therapeutic exercises were medically necessary to treat this patient's medical condition for the dates of service 10/09/03 through 01/07/04.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn
Attachment