

MDR Tracking Number: M5-04-4146-01

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 08-05-04.

The IRO reviewed office visits, electrical stimulation, therapeutic procedures, neuromuscular re-education, therapeutic activities, manual therapeutic techniques, chiropractic manipulation, gait training, massage, unlisted therapeutic procedures, diathermy and mechanical traction therapy rendered from 08-15-03 through 04-28-04 that were denied based upon "U".

The IRO determined that the electrical stimulation on 08-15-03 **was** medically necessary. The IRO determined that the electrical stimulation (except on 08-15-03), office visits, therapeutic procedures, neuromuscular re-education, therapeutic activities, manual therapeutic techniques, chiropractic manipulation, gait training, massage, unlisted therapeutic procedures, diathermy and mechanical traction therapy from 08-15-03 through 04-28-04 **were not** medically necessary.

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 09-02-04, 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.

Review of CPT codes 97140-59 and 98941 on dates of service 08-06-03, 08-08-03, 08-11-03, 08-13-03, 08-15-03, 08-20-03, 08-22-03, 08-25-03, 08-29-03, 09-03-03, 09-04-03, 09-05-03, 09-10-03, 09-12-03, 09-15-03, 09-22-03, 09-26-03, 11-17-03, 11-24-03, 11-25-03, 12-08-03, CPT code 97530 dates of service 08-22-03, 09-15-03, 11-03-03, 11-25-03, 02-25-04, code 97110 dates of service 08-22-03, 09-15-03, 11-03-03, 11-25-03, 02-25-04, 02-27-04, code 97112 dates of service 08-22-03, 09-15-03, 09-22-03, 11-03-03, 11-14-03, 11-25-03, 02-25-04, 02-27-04, code 99213-MP dates of service 08-29-03, 09-29-03, 11-25-03, 12-02-03, 02-25-04, 02-27-04, 03-01-04, 03-10-04, 03-19-04, 03-22-04, 03-26-04, 04-02-04, 04-05-04, 04-07-04, 04-12-04 and 04-28-04, code 97140-59 dates of service 10-13-03, 10-15-03, 10-20-03, 10-22-03, 10-27-03, 10-29-03, 11-14-03, 11-20-03, 11-21-03, 12-02-03, 12-05-03, 12-10-03, 12-12-03, 12-15-03, 12-19-03, 04-02-04, code 98941 dates of service 02-06-04, 02-18-04, code 97032 dates of service 02-25-04, 02-27-04, code 97116 date of service 02-27-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement recommended.

CPT code 99213-MP (9 DOS) dates of service 08-06-03, 08-08-03, 08-11-03, 08-13-03, 08-20-03, 08-22-03, 09-22-03, 09-26-03 and 11-21-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. The MAR per Rule 134.202(c)(1) is \$66.19 (\$52.95 X 125%). The requestor billed \$48.00 for each date of service in dispute. Reimbursement is recommended in the amount of **\$432.00 (\$48.00 X 9 DOS)**.

CPT code 97032 (5 DOS) dates of service 08-06-03, 08-08-03, 08-11-03, 08-13-03 and 08-20-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Per Rule 134.202(c)(1) reimbursement is recommended in the amount of **\$104.25 (\$16.68 X 125% = \$20.85 X 5 DOS)**.

CPT code 97139-SS (6 DOS) dates of service 08-06-03, 08-08-03, 08-11-03, 08-15-03 and 08-20-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Per Rule 134.202(c)(1) reimbursement is recommended in the amount of **\$122.76 (\$16.37 X 125% = \$20.46 X 6 DOS)**.

CPT code 99080-73 dates of service 08-29-03 and 09-29-03 denied with denial code "F/TD" (the work status report was not properly completed or was submitted in excess of the filing requirements, therefore, reimbursement is denied per Rule 129.5). The carrier has not made any payment. The requestor did not submit documentation for review. No reimbursement recommended.

CPT code 97112 (3 units) date of service 09-26-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment per the respondent although the EOB submitted indicates payment being made. The MAR per Rule 134.202(c)(1) is \$110.82 ( $\$29.55 \times 125\% = \$36.94 \times 3$  units). The requestor listed \$107.70 in dispute. Reimbursement is recommended in the amount of **\$107.70**.

CPT code 97112 (9 units) dates of service 10-06-03, 10-08-03, 10-13-03 and 10-15-03 denied with denial code "D" (duplicate). Since neither party submitted original EOBs the review will be per Rule 134.202. The MAR per Rule 134.202(c)(1) is \$332.46 ( $\$29.55 \times 125\% = \$36.94 \times 9$  units). The requestor listed \$107.70 in dispute for each date of service. Reimbursement recommended in the amount of **\$323.10**.

CPT code 97530 (8 units) dates of service 10-08-03, 10-13-03, 10-15-03 and 11-17-03 denied with denial code "D" (duplicate). Since neither party submitted original EOBs the review will be per Rule 134.202. Per Rule 134.202(c)(1) reimbursement is recommended in the amount of **\$291.84 ( $\$29.18 \times 125\% = \$36.48 \times 8$  units)**.

CPT code 97110 dates of service 10-08-03, 10-13-03, 10-15-03 and 11-17-03 denied with denial code "D" (duplicate). 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. Reimbursement not recommended.

CPT code 99213-MP dates of service 10-20-03 and 11-17-03 denied with denial code "D" (duplicate). Since neither party submitted original EOBs the review will be per Rule 134.202. The MAR per Rule 134.202(c)(1) is \$66.19 ( $\$52.95 \times 125\%$ ). The requestor billed \$48.00 for each date of service in dispute. Reimbursement is recommended in the amount of **\$96.00 ( $\$48.00 \times 2$  DOS)**.

#### **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 the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), 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 08-06-03 through 11-21-03 in this dispute.

This Findings and Decision and Order are hereby issued this 28th day of February 2005.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division  
DLH/dlh  
Enclosure: IRO Decision

#### **NOTICE OF INDEPENDENT REVIEW DECISION**

October 11, 2004

**Amended Letter 02/10/05**

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 #: M5-04-4146-01  
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 50 year-old male developed lower back and groin pain while lifting a tire on \_\_\_\_\_. He underwent a two-level decompression and one-level discectomy on 05/10/04. Treatment prior to surgery included medication, epidural steroid injection, extensive physical therapy, and chiropractic therapies.

#### Requested Service(s)

Office visits – 08/15/03, 8/25/03, 09/03/03-09/15/03, 12/12/03, 03/01/04-03/03/04, 03/15/04, 03/29/04-03/31/04, 04/14/04

Electrical stimulation – 08/15/03, 11/10/03, 01/30/04, 03/19/04

Therapeutic procedures - 08/25/03-09/12/03, 09/22/03-10/01/03, 10/20/03-10/29/03, 11/14/03-11/24/03, 12/02/03-02/20/04, 03/01/04-04/28/04

Neuromuscular reeducation – 08/25/03-09/12/03, 09/29/03-10/01/03, 10/20/03-10/29/03, 11/17/03-11/24/03, 12/02/03-02/20/04, 03/01/04-04/28/04

Therapeutic activities – 09/10/03-09/12/03, 09/22/03-10/06/03, 10/15/03-10/29/03, 11/14/03-11/24/03, 12/02/03-02/18/04, 03/01/04-04/28/04

Manual therapeutic techniques – 09/29/03-10/06/03, 10/29/03, 01/28/04-03/31/04, 04/05/04-04/12/04

Chiropractic manipulation – 09/29/03-11/21/03, 12/02/03-02/04/04

Gait training – 01/12/04-02/20/04, 03/03/04-04/28/04

Massage – 01/28/04-03/01/04

Unlisted therapeutic procedures - 01/28/04-01/30/04

Diathermy and mechanical traction therapy for dates of service 08/15/03 through 04/28/04

### Decision

It is determined that the electrical stimulation on 08/15/03 was medically necessary to treat this patient's medical condition.

However, all electrical stimulation except on 08/15/03, office visits, therapeutic procedures, neuromuscular reeducation, therapeutic activities, manual therapeutic techniques, chiropractic manipulation, gait training, massage, unlisted therapeutic procedures, diathermy and mechanical traction therapy were not medically necessary to treat this patient's medical condition on the dates listed.

### Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type, and duration of services must be reasonable and consistent with the standards of the health care community. Those criteria were not met in this case.

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters* states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Based on these guidelines, the electrical stimulation on 08/15/03 would have been medically indicated since they fell within the 4-week period from 07/25/03 through 08/22/03. All other items in question are denied because no documentation was submitted to indicate or support its medical necessity.

Therapeutic exercises may be performed in a clinic one-on-one, in a clinic in a group, at a gym, or at home. The provider has failed to establish why the services were required to be performed one-on-one. Physical medicine also requires ongoing assessment of a patient's response to prior treatment and modification of treatment activities to effect additional gains in function. Continuation of an unchanging treatment plan, performance of activities that can be performed at home, and/or modalities that provide the same effects as those that can be self-administered are not indicated.

The records fail to substantiate that the services provided fulfilled the Texas Worker's Compensation Commission's statutory requirements for medical necessity. Specifically, the patient obtained little or no relief, with his pain rating remaining at 8 to 9 on a scale of 10 throughout the treatment; promotion of recovery was not accomplished since surgery was eventually necessary; and the disputed treatment did not enhance the employee's ability to return to employment. Therefore, the office visits, electrical stimulation (excluding 08/15/03), therapeutic procedures, neuromuscular reeducation, therapeutic activities, manual therapeutic techniques, chiropractic manipulation, gait training, massage, unlisted therapeutic procedures, diathermy and mechanical traction therapy were determined to be not medically necessary to treat this patient's medical condition for dates of service 08/15/03 through 04/28/04.

Sincerely,

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

GBS:vn

Attachment

**Attachment**

**Information Submitted to TMF for TWCC Review**

**Patient Name:**

**TWCC ID #: M5-04-4146-01**

**Information Submitted by Requestor:**

- Chiropractic notes 07/23/03-04/28/04
- Therapy progress notes 08/06/03-04/28/04
- MD office notes 09/08/03–08/10/04
- Myelogram/MRI reports
- Designated doctor evaluation 11/05/03

**Information Submitted by Respondent:**