

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-4066.M5

MDR Tracking Number: M5-04-4212-01

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. This dispute was received on 8-13-04.

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: 8-12-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that office visits, therapeutic exercises, massage therapy, re-freezable cryo packs, DME, consumable TENS supplies, biofreeze, group therapeutic procedures, electrical stimulation therapy, chiropractic manipulation-spinal, muscle testing and mechanical traction therapy - full spine for 8-13-03 through 11-4-03 (which were denied with “U” or “Y” since “medical necessity prevails over payment policies”) were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

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 9-14-04, 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.

Regarding CPT code 97110 for dates of service 8-13-03, 8-15-03, 8-18-03, 8-20-03, 8-22-03, 9-24-03, 9-26-03, 10-01-03, 10-8-03 and 10-10-03 was denied by the carrier with a “Y” or a “D”: 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.

Reimbursement not recommended.

CPT code 98940 on dates 8-13-03 and 8-20-03 of service was denied with a "G" – The value of the procedure is included in the value of another procedure performed on this date." Per rule 133.304 (c) Carrier didn't specify which service this was global to, therefore it will be reviewed according to the Medicare Fee Schedule. **Recommend reimbursement of \$60.26. (\$30.13 x 2)**

CPT code 97139-EU on dates of service 8-13-03, 8-15-03, 8-20-03 and 8-22-03 was denied with an "N" –." Not appropriately documented. The requestor did submit additional information regarding this service. **Recommend reimbursement of \$73.00. (\$18.25 x 4)**

CPT code 98940 on dates of service on 9-24-03, 10-1-03 and 10-8-03, was denied with a "D" (duplicate). Per rule 133.304 (c) the carrier didn't specify which service this was a duplicate to, therefore it will be reviewed according to the Medicare Fee Schedule. **Reimbursement per the Medicare Fee Guidelines is recommended in the amount of \$90.39. (\$30.13 x 3)**

CPT code 97150 on dates of service on 9-24-03, 9-26-03, 10-01-03,10-08-03, and 10-10-03, was denied with a "D" (duplicate). Per Rule 133.304 (c) the carrier didn't specify which service this was a duplicate to, therefore it will be reviewed according to the Medicare Fee Schedule. **Reimbursement per the Medicare Fee Guidelines is recommended in the amount of \$106.85. (\$21.37 x 5)**

CPT code 97139 on dates of service on 9-24-03, 10-08-03, 10-10-03 and 10-13-03 was denied with a "D" (duplicate). Per Rule 133.304 (c) the carrier didn't specify which service this was a duplicate to, therefore it will be reviewed according to the Medicare Fee Schedule. **Reimbursement per the Medicare Fee Guidelines is recommended in the amount of \$73.00. (18.25 x 4)**

CPT code 97124 on dates of service on 9-24-03, 9-26-03, 10-08-03, 10-10-03 and 10-13-03 was denied with a "D" (duplicate). Per Rule 133.304 (c) the carrier didn't specify which service this was a duplicate to, therefore it will be reviewed according to the Medicare Fee Schedule. **Reimbursement per the Medicare Fee Guidelines is recommended in the amount of \$128.45. (\$25.69 x 5)**

CPT code 99070 on dates of service on 9-24-03 and 11-12-03 was denied with a "D" (duplicate). Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. **No reimbursement recommended.**

CPT code 98943 on dates of service on 10-01-03 and 10-08-03 was denied with a "D" (duplicate). This code reports a procedure, service or supply that is not covered or valid for Medicare. Per rule 133.304 (c) the carrier didn't specify which service this was a duplicate to, therefore it will be reviewed according to the Medicare Fee Schedule. **Reimbursement per the Medicare Fee Guidelines is recommended in the amount of \$55.94. (\$27.97 x 2)**

The carrier denied CPT Code 99080-73 with a U for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Requester submitted relevant information to support delivery of service. **Per Rule 129.5 recommend reimbursement of CPT Code 99080-73 for \$15.00.**

CPT code 97750-MT on date of service 11-12-03 was denied with a "D" (duplicate). Per Rule 133.304 (c) the carrier didn't specify which service this was a duplicate to, therefore it will be reviewed according to the Medicare Fee Schedule. **Reimbursement per the Medicare Fee Guidelines is recommended in the amount of \$133.60. (\$33.40 x 4)**

CPT code 95851 on date of service 11-12-03 was denied with a "D" (duplicate). Per Rule 133.304 (c) the carrier didn't specify which service this was a duplicate to, therefore it will be reviewed according to the Medicare Fee Schedule. **Reimbursement per the Medicare Fee Guidelines is recommended in the amount of \$30.60.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fee in accordance with Medicare program reimbursement methodologies for dates of service after 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 8-13-03 through 11-12-03 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 21st day of December 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity
IRO Decision Notification Letter**

Date: December 17, 2004
Injured Employee:
MDR #: M5-04-4212-01
TWCC #:
MCMC Certification #: 5294

Requested Services: office visit (99212), therapeutic exercised (97110), massage therapy (97124), re-freezable cryo packs (99070-DME #33), consumable TENS supplies (99070-DME #5 or 6), biofreeze (99070-DME #28), group therapeutic procedures (97150), electrical stimulation therapy (7139 EU), chiropractic manipulation-spinal (98940, 98941), Delorme muscle testing (97750), mechanical traction therapy-full spine (97012). Denies by carrier for Medical Necessity with "U" Codes

MCMC llc (MCMC) is an Independent Review Organization (IRO) that was selected by The Texas Workers' Compensation Commission to render a recommendation regarding the medical necessity of the above Requested Service.

Please be advised that a MCMC Physician Advisor has determined that your request for M5 Retrospective Medical Necessity, Medical Dispute Resolution on 12/17/2004 concerning the medical necessity of the above references requested service hereby **Upholds the carrier's decision that the requested services are not medically necessary.** The decision is based on:

- *Summary of Provider's Position dated 10/04/2004
- *35 pgs Patient Office Visits Reports
- *Initial Medical Narrative Report dated 08/12/2003, 09/30/2003, 11/12/2003
- *(3)Lumbar ROM Assessment Report date unknown
- *TWCC Status Report dated 08/18/2003, 09/17/2003, 10/01/2003, 10/31/2003, 11/05/2003, 11/15/2003, 12/16/2003
- *3 pgs Muscle Strength Testing (DeLorme Testing)
- *3 pgs Special Testing (Critical Job Demand Testing)
- *6 pgs Treatment Plan
- *Therapeutic Procedures Chart dated 08/13/2003, 08/15/2003, 08/18/2003, 08/20/2003, 08/22/2003, 08/29/2003, 09/02/2003, 09/03/2003, 09/05/2003, 09/08/2003, 09/12/2003, 09/15/2003, 09/17/2003, 09/24/2003, 09/26/2003, 10/01/2003, 10/08/2003, 10/10/2003, 10/17/2003, 10/20/2003, 10/24/2003,
- *2 pgs Biofreeze 4oz tube
- *1 pg LSI Silver self adhesive electrodes
- *2 pgs Radiology Report
- *16 pgs Assessment and Psychological Status Report
- *Report of Medical Evaluation dated 11/26/2003

- *5 pgs DD Report dated 11/26/2003
- *3 pgs Exhibit SCD-I
- *9 pgs Annotated Bibliography
- *14 pgs Some Medical Evidence Relied Upon To Form Basis of Medical Opinions
- *Notification of IRO Assignment
- *IRO Acknowledgment and Invoice Notification Letter
- *6 pgs Medical Dispute Resolution Request/Response
- *Explanation of Benefits dated 10/22/2003, 11/05/2003, 11/07/2003, 02/20/2004,
- *IRO Notification Letter

After careful review of the documentation submitted and consistent with standards of care and practice within the chiropractic profession as well as based on reasonably expected clinical outcomes, this reviewer is in agreement with the previous denial.

The documentation does not provide the substantiation for the medical necessity of the level of care provided this injured individual. The alleged date of injury is listed as _____. It should be noted that the injured individual did not seek medical care for almost two weeks at which time he presented to the emergency room. The injured individual was apparently offered medication management, from which there is no indication of response, and physical therapy. The injured individual participated in two weeks of the physical therapy, which was reported to have provided positive results. Some three months post injury and with as much as a two-month gap in care, the injured individual sought care under the supervision of the current attending physician. This shows a low motivation for seeking formal care, and, without further explanation, an apparent indicator of the low severity of injury.

Furthermore, there is nothing in the documentation to suggest that this case is particularly complicated or contains co-morbidities that could be reasonably expected to delay recovery and warrant a protracted and aggressive course of care. MRI examination was negative for significant pathology and no other advanced testing was performed to indicate that the injured individual had significant complicating factors to warrant the level and duration of the care provided. By the time that the injured individual presented to the office of the attending physician, the expected natural history of this particular condition had already passed. The natural history for most uncomplicated low back sprain type injuries is typically observed as 4-12 weeks.

Moreover, there is little indication that the injured individual was positively benefiting from the course of care from a subjective standpoint. The daily notes indicate that the reported subjective pain levels dropped from 9 to 4/10 after the initial visit. Interestingly, the subjective pain levels never again changed through the remainder of the initial two weeks of chiropractic intervention. Further review reveals that the subjective pain levels remained basically constant throughout the remainder of the documented course of care. There were even times when the reported pain levels rose sharply only to drop back to the same basic 4/10 level. It is apparent from a

retrospective review of the clinical file that from a subjective standpoint, the care provided was not proving to be efficacious in regards to this particular injured individual and his particular injuries.

Also, the level of care provided, inclusive of all the modalities and services listed above, does not match favorably with the level of injury or the diagnoses. This injured individual was prescribed as many as eight units of therapeutic exercises per date of treatment, along with a litany of passive modalities for the treatment of a simple lumbar sprain/strain for which the injured individual did not even actively seek care for a two plus month period. There are no indications within the documentation that this level of care and services was substantiated or required based on the level and severity of injury, clinical findings and subsequent symptomatology.

The reviewing provider is a licensed Chiropractor and certifies that no known conflict of interest exists between the reviewing Chiropractor and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO. The reviewing physician is on TWCC's Approved Doctor List.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5)).

In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of TWCC on this

17th day of December 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee: _____