

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

SOAH DOCKET NO. 453-05-4163.M5

MDR Tracking Number: M5-04-4243-01

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 08-16-04.

The IRO reviewed office visits, manual therapy, massage therapy, therapeutic exercises, neuromuscular re-education, educational supplies, chiropractic manipulative treatment, muscle testing and range of motion measurements rendered from 08-26-03 through 05-26-04 that were denied based upon "V".

The IRO determined that the office visits, m annual therapy, massage therapy, therapeutic exercises, neuromuscular re-education, educational supplies, chiropractic manipulative treatment, muscle testing and range of motion measurements from 08-26-03 through 02-13-04 **were** medically necessary. The IRO determined that services from 02-14-04 through 05-26-04 **were not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above services.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of 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.

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 09-16-04, 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 95831 date of service 08-28-03 (1 unit) denied with denial code "N" (not appropriately documented). The requestor did not submit documentation for review. No reimbursement recommended.

CPT code 95831 date of service 08-28-03 (1 unit) denied with denial code "G" (unbundling). Per Rule 133.304(c) the carrier did not specify which service this was global to. The service is reviewed per the Medicare Fee Schedule effective 08-01-03. Reimbursement is recommended in the amount of \$37.04 (\$29.63 X 125%).

CPT code 95831 date of service 08-28-03 (1 unit) denied with denial code "JM" (accurate coding of services is essential for proper reimbursement. The code or modifier billed is invalid). Per the Medicare Fee Schedule the code billed is valid. Reimbursement is recommended in the amount of \$37.04 (\$29.63 X 125%).

CPT code 95851 date of service 08-28-03 denied with denial code "G" (unbundling). Per Rule 133.304(c) the carrier did not specify which service this was global to. The service is reviewed per the Medicare Fee Schedule effective 08-01-03. Reimbursement is recommended in the amount of \$33.40 (\$26.72 X 125%).

Review of CPT code 98940 dates of service 09-02-03 and 09-04-03 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not submit convincing evidence of carrier receipt of the providers request for EOBs. Per Rule 133.307(e)(3)(B) the respondent did not submit EOBs as required. No review by the Medical Review Division is performed for these services. No reimbursement recommended.

CPT code 99213 date of service 09-05-03 denied with denial code "D" (duplicate). Per Rule 133.304(c) the carrier did not specify which service this was a duplicate to. Reimbursement per the Medicare Fee Schedule is recommended in the amount of \$62.81 ($\$50.25 \times 125\%$).

CPT code 97112 date of service 09-05-03 denied with denial code "D" (duplicate). Per Rule 133.304(c) the carrier did not specify which service this was a duplicate to. Reimbursement per the Medicare Fee Schedule is recommended in the amount of \$35.26 ($\$28.21 \times 125\%$).

CPT code 97110 date of service 09-05-03 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. 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

Review of CPT codes 97140 and 97124 on dates of service 09-09-03, 09-10-03, 09-16-03 and 01-27-04, codes 99211, 97112 and 97110 on 01-27-04 and code 99213 on 05-17-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not submit convincing evidence of carrier receipt of the providers request for EOBs. Per Rule 133.307(e)(3)(B) the respondent did not submit EOBs as required. No review by the Medical Review Division is performed for these services. No reimbursement recommended.

CPT code 95831 (3 units) date of service 09-16-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Reimbursement per the Medicare Fee Schedule is recommended in the amount of \$111.12 ($\$29.63 \times 125\% = \37.04×3 units).

CPT code 95851 dates of service 09-16-03 and 12-03-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Reimbursement per the Medicare Fee Schedule is recommended in the amount of \$66.80 ($26.72 \times 125\% = \33.40×2 DOS).

CPT code 99071 date of service 09-16-03 denied with denial code "G" (unbundling). Per Rule 133.304(c) the carrier did not specify which service this was global to. The service is reviewed per the Medicare Fee Schedule effective 08-01-03. Reimbursement is recommended in the amount of \$25.00.

CPT code 98940 date of service 10-13-03 denied with denial code "F" (fee guideline MAR reduction). The MAR per the Medicare Fee Schedule is $\$25.34 \times 125\% = \31.68 . The requestor billed \$25.34 and the carrier has made a payment of \$25.00. Additional reimbursement in the amount of \$0.34 is recommended.

CPT code 99080-73 dates of service 12-03-03, 02-10-04 and 02-23-04 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Per Rule 133.106(f)(1) reimbursement is recommended in the amount of \$45.00 ($\15.00×3 DOS).

CPT code 97140 date of service 12-03-03 denied with denial code "G" (unbundling). Per Rule 133.304(c) the carrier did not specify which service this was global to. The service is reviewed per the Medicare Fee Schedule effective 08-01-03. The MAR is \$32.55 (\$26.04 X 125%). However the requestor billed \$26.04 therefore reimbursement is recommended in the amount of \$26.04.

CPT code 97124 dates of service 12-03-03, 12-04-03, 12-05-03, 12-08-03 and 12-09-03 denied with denial code "G" (unbundling). Per Rule 133.304(c) the carrier did not specify which service this was global to. The service is reviewed per the Medicare Fee Schedule effective 08-01-03. The MAR is \$27.14 (\$21.71 X 125%). The requestor billed \$21.71 for each date of service in dispute. Reimbursement is recommended in the amount of \$108.55 (\$21.71 X 5 DOS).

This Findings and Decision is hereby issued this 6th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

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 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 08-26-03 through 02-23-04 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 Order is hereby issued this 6th day of January 2005.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

October 26, 2004

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 #: M5-04-4243-01
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 54 year-old male patient was involved in a motor vehicle accident on ____, resulting in a gradual onset of headaches, neck pain, and low back pain. He underwent open decompression and rotator cuff repair of the right shoulder on 11/25/03. His treatment has included chiropractic care and physical therapy pre and post surgery.

Requested Service(s)

Office visits, manual therapy, massage therapy, therapeutic exercises, neuromuscular reeducation, educational supplies, chiropractic manipulative treatment, muscle testing, and range of motion measurements for dates of service 08/26/03 through 05/26/04

Decision

It is determined that there is medical necessity for the office visits, manual therapy, massage therapy, therapeutic exercises, neuromuscular reeducation, educational supplies, chiropractic manipulative treatment, muscle testing, and range of motion measurements for dates of service 08/26/03 through 02/13/04 but there is no medical necessity from 02/14/04 through 05/26/04.

Rationale/Basis for Decision

The office visits, manual therapy, massage therapy, therapeutic exercises, neuromuscular reeducation, educational supplies, chiropractic manipulative treatment, muscle testing, and range of motion measurements for dates of service 08/26/03 through 02/13/04 were medically necessary and appropriate both prior to the surgical application and a trial of post-operative rehabilitation application. A functional capacity evaluation was performed on 02/13/04 that indicated a work-conditioning program would be appropriate to provide the claimant a chance to increase his physical demand capacity. Guidelines of clinical practice and peer-reviewed references indicate that the continuation of the office visits, manual therapy, massage therapy, therapeutic exercises, neuromuscular reeducation, educational supplies, chiropractic manipulative treatment, muscle testing, and range of motion measurements after this recommendation were not appropriate nor medically necessary to treat this

patient's medical condition. Therefore, the questioned services from 08/26/03 through 02/13/04 were medically necessary however services from 02/14/04 through 05/26/04 were not medically necessary to treat this patient's medical condition.

Sincerely,

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

GBS:vn