

MDR Tracking Number: M5-04-4267-01

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 08-17-04.

The IRO reviewed office visits, minimal (99211), office visits, expanded problem-focused (99213), office visits, re-evaluation (99214), therapeutic exercises (97110), manual therapy techniques (97140-59), neuromuscular re-education (97112) and physical team conferences (99361) for dates of services 12-10-03 through 04-15-04. Note: office visits expanded-problem focused only (99213) for dates of service 10-13-03, 10-30-03 and 11-25-03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the 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 09-17-04, 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 codes 97112 and 97140-59 dates of service 10-09-03, 10-13-03, 10-16-03, 10-30-03, 11-18-03, 11-24-03 and 11-25-03 denied with denial code "N" (not appropriately documented). The requestor did not submit documentation for review. No reimbursement is recommended.

CPT code 97110 dates of service 10-13-03 through 11-25-03 (8 DOS) denied with denial code "N" (not appropriately documented). 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. Additional reimbursement not recommended.

CPT code 97140-59 (4 units) dates of service 10-15-03 and 10-29-03 denied with denial code "N" (not appropriately documented). The requestor submitted information that met documentation criteria. Reimbursement per the Medical Fee Guideline effective 08-01-03 is \$130.20 ( $\$26.04 \times 125\% = \$32.55 \times 4$  units). The requestor billed \$117.18. Additional reimbursement is recommended in the amount of \$58.60 (\$117.18 minus carrier payment of \$58.58).

CPT code 97112 (6 units) dates of service 10-15-03 and 10-29-03 denied with denial code "N" (not appropriately documented). The requestor submitted information that met documentation criteria. Additional reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of \$141.04 ( $\$28.21 \times 125\% = \$35.26 \times 6$  units – \$211.56 minus carrier payment of \$70.52)

### **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 10-15-03 and 10-29-03 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 Findings and Decision and Order are hereby issued this 6th day of December 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-4267-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

October 7, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

### CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. 2-page Summary of Position of Respondent, prepared by its attorneys, dated 09/27/04
3. Lumbar MRI report from Lone Star Open MRI, Inc., dated 06/10/03
4. Comparative Muscle/ROM Tests from "ATI" dated 10/15/03 and 10/29/03
5. Initial narrative report from referral physical medicine and rehabilitation specialist, dated 11/11/03 and then handwritten "Patient Assessment" notes from same doctor for multiple visits thereafter
6. Narrative report from referral spinal surgeon dated 11/19/03
7. Left sacroiliac joint block operative report from Texas Imaging & Diagnostic Center dated 01/09/04
8. Narrative daily SOAP notes from the treating doctor of chiropractic for 10/13/03 through 08/10/04

Patient is a 47-year-old female claims analyst who, on \_\_\_\_, injured her lower back when she lifted a large water container to the top of a cooler. Thereafter, she had gradual onset of pain with relatively rapid progression over two to three days whereupon she sought medical care, which included physical therapy and a left sacroiliac joint injection in July 2003. She then received post-injection aqua therapy, was then declared MMI with 1% whole-person impairment, and released. (She was later seen by a carrier-selected doctor who determined she had a 5% whole-person impairment.) On 10/09/03, she obtained approval for a change of treating doctor and initiated care with a doctor of chiropractic. He began chiropractic care, including more physical therapy, and referred her to an orthopedic physical medicine/rehabilitation specialist and a reconstructive spinal surgeon.

### REQUESTED SERVICE(S)

Office visits, minimal (99211), office visits, expanded problem-focused (99213), office visits, reevaluation (99214), therapeutic exercises (97110), manual therapy techniques (97140-59),

neuromuscular reeducation (97112), and physician team conferences (99361) for dates of service 12/10/03 through 04/15/04. [Note: Office visits, expanded-problem focused, only (99213) for dates of service 10/13/03, 10/30/03 and 11/25/03.]

#### DECISION

Denied.

#### 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. General expectations include: (A) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (B) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (C) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (D) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment.

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains.

In this case, there is no documentation of objective or functional improvement in this patient's condition and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment. In fact, the treating doctor's daily notes were nearly super imposable upon one another, and lacked any objective measurements regarding

specific patient response and/or improvement (e.g., range of motion values, neurological and/or orthopedic monitoring), and frequently were contradictory in nature. Specifically, the daily notes consisted of computer-generated commentary such as:

“The patient is progressing as expected with conservative care. The patient is improving slowly at this time” [written on the same date of service].

“The patient presented today for an office visit. The patient’s condition was discussed in regards to the progress, changes in symptomatology and prognosis. Counseling and/or advice was provided to the patient. Patient received 45 minutes of therapeutic exercises (which may consist of one or more of the following items: recumbent bike, aerodyne bike, ergometer, treadmill, cybex active weight equipment). The patient received two units of manual techniques that consist of one or more of the following: mobilization, manual lymphatic drainage, and/or manual traction...”

Therefore, since no valid medical records were provided upon which to base continued care, its medical necessity was not supported.

Current medical literature states, “...there is no strong evidence for the effectiveness of supervised training as compared to home exercises.”<sup>1</sup> As mentioned previously, home exercise is an important component of any ongoing rehabilitation program, and the medical records were devoid of any mention regarding the initiation this type of program in this case.

And finally, the medical records submitted fail to document that chiropractic spinal adjustments were performed at any time. According to the AHCPR<sup>2</sup> guidelines, spinal manipulation was the

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<sup>1</sup> Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.

<sup>2</sup> Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.

nly recommended treatment that could relieve symptoms, increase function and hasten recovery for adults suffering from acute low back pain. Based on those findings, this reviewer is cannot understand why a doctor of chiropractic would withhold this recommended treatment while performing a host of other non-recommended therapies.