

MDR TRACKING #: M5-05-1651-01
Previous Tracking #: M5-05-0873-01

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 11-15-04.

In a letter dated 2-7-05 the Requestor withdrew CPT code 99212 for 12-12-03. This service will not be a part of this dispute.

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, unusual travel, therapeutic exercise, mechanical traction, chiropractic manipulation, neuromuscular re-education, supplies and materials and massage from 1-07-04 through 8-13-04 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 12-09-04, 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.

Neither the carrier nor the requestor provided EOB's for CPT code 99212 for date of service 12-24-03. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). This violation will be referred to Compliance and Practices. **Recommend reimbursement of \$46.41.**

The carrier denied CPT code 99212 for date of service 1-21-04 with an "R" – extent of injury. The TWCC 21 provided by the carrier states "The compensable body part is limited to a lumbar back strain only." Per the HCFA provided by the requestor the diagnosis codes were 722.2 (displacement disc site uns w/o myelopathy) and 724.4 (thoracic lumbosacral neuritis/radiculitis uns). These were compensable items. This violation will be referred to Compliance and Practices. **Recommend reimbursement of \$46.41.**

The carrier denied CPT code 99212 for date of service 1-23-04 with a "G" – Global. Per rule 133.304 (c) Carrier didn't specify which service this was global to. **Recommend reimbursement of \$46.41.**

The carrier denied CPT code 98940 for dates of service 1-21-04 and 1-23-04 with an “R” – extent of injury. The TWCC 21 provided by the carrier states “The compensable body part is limited to a lumbar back strain only.” Per the HCFA provided by the requestor the diagnosis codes were 722.2 (displacement disc site uns w/o myelopathy) and 724.4 (thoracic lumbosacral neurit /radiculit uns). These were compensable items. This violation will be referred to Compliance and Practices.

Recommend reimbursement of \$65.68 (\$32.84 X 2 DOS).

The carrier denied CPT code 97012 for date of service 1-23-04 with an “R” – extent of injury. The TWCC 21 provided by the carrier states “The compensable body part is limited to a lumbar back strain only.” Per the HCFA provided by the requestor the diagnosis codes were 722.2 (displacement disc site uns w/o myelopathy) and 724.4 (thoracic lumbosacral neurit /radiculit uns). These were compensable items. This violation will be referred to Compliance and Practices.

Recommend reimbursement of \$18.83.

Regarding CPT code 99212 on 5-21-04 and 7-16-04: Neither the carrier nor the requestor provided EOB’s for date of service. The requestor submitted convincing evidence of carrier receipt of provider’s request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB’s Per Rule 133.307(e)(3)(B). This violation will be referred to Compliance and Practices.

Recommend reimbursement of \$92.82 (\$46.41 X 2 DOS).

Regarding CPT code 98940 on 5-21-04: Neither the carrier nor the requestor provided EOB’s for date of service. The requestor submitted convincing evidence of carrier receipt of provider’s request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB’s Per Rule 133.307(e)(3)(B). This violation will be referred to Compliance and Practices. **Recommend reimbursement of \$32.84.**

Regarding CPT code 97110 (3 units each) on 1-21-04, 1-23-04 and 5-21-04: These services were denied with an “R” (1-21-04) or no EOB was provided (5-21-04): 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.**

Regarding CPT code 99082 on 7-7-04: Neither the carrier nor the requestor provided EOB’s for date of service. The requestor submitted convincing evidence of carrier receipt of provider’s request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB’s Per Rule 133.307(e)(3)(B). This violation will be referred to Compliance and Practices. **Recommend reimbursement of \$46.50.**

Regarding CPT code 97012 on 8-13-04: Neither the carrier nor the requestor provided EOB's for date of service. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). This violation will be referred to Compliance and Practices. **Recommend reimbursement of \$18.83.**

Pursuant to 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 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 12-24-03 through 8-13-04 as outlined above in this dispute.

This Decision and Order is hereby issued this 8th day of February , 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

February 3, 2005

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 #: M5-05-0873-01
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 Medicine. 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 33 year-old female injured her back on 12/05/01 while throwing trash bags into a dumpster. Her diagnosis is acute lumbar strain that has developed into chronic lumbar radicular syndrome. She has been treated with medications, therapy, epidural injections and surgery.

Requested Service(s)

Office visit, unusual travel, therapeutic exercise, mechanical traction, chiropractic manipulation, neuromuscular re-education, supplies and materials, massage for dates of service 01/07/04 through 08/13/04

Decision

It is determined that there is no medical necessity for the office visit, unusual travel, therapeutic exercise, mechanical traction, chiropractic manipulation, neuromuscular re-education, supplies and materials, massage for dates of service 01/07/04 through 08/13/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation does not indicate the necessity for the services in question. The patient has received over two years of treatment and has shown some improvement. However, in this case, occasional medication management and a home exercise program are applicable. Home exercises are preferred because the patient can perform them on a daily basis. There is no evidence to support the need for monitored therapy. From a physical standpoint, there was no clinical justification or acceptable national treatment guideline that would allow for her to receive the services in question. Therefore, the office visit, unusual travel, therapeutic exercise, mechanical traction, chiropractic manipulation, neuromuscular re-education, supplies and materials, and massage for dates of service 01/07/04 through 08/13/04 are not medically necessary to treat this patient's medical condition.

Sincerely,

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

GBS:dm

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-0873-01

Information Submitted by Requestor:

- Progress Notes
- Diagnostic Tests
- Procedure Notes

Information Submitted by Respondent:

- Peer Review



TEXAS
WORKERS' COMPENSATION COMMISSION
7551 METRO CENTER DRIVE, SUITE 100, MS-48, AUSTIN, TEXAS 78744-7551
(512) 804-4800

MEMORANDUM

DATE: ___/___/ 2005

TO: Austin Commission Representative

CARRIER: Travelers Indemnity Company, Box 05

FROM: Medical Review Division, 7551 Metro Center Drive Suite # 100

RE: **NOTICE of Independent Review Organization and
Medical Dispute Resolution DECISION & ORDER**

This memorandum shall serve as your notice to present yourself to the Mail Room Service Counter:

(X) An IRO and MDR Decision & Order.

The above referenced document has been issued in a medical dispute case review pertaining to the following claimant and insurance carrier:

IDENTIFIER

MDR TRACKING #: M5-05-0873-01
TWCC FILE #: 02009304
CLAIMANT: Kim A. Harris
DOI: 12-05-01
SERVICE FROM: 12-12-03
SERVICE TO: 8-13-04

I, the undersigned Representative of the above referenced insurance carrier, do hereby acknowledge receipt of the IRO and MDR Decision & Order applicable to a medical dispute resolution request solicited by the requestor.

Receipt of this Decision & Order is hereby acknowledged this ___ day of _____ 2005.

Signature of Commission Representative: _____

Printed Name of Commission Representative: _____