

MDR Tracking Number: M5-05-0112-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 9-7-04.

The IRO reviewed office visits, therapeutic exercises, therapeutic activities, and neuromuscular re-education on 8-11-03 through 12-9-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO determined that the following services on the following dates of service were medically necessary. The IRO agrees with the previous adverse determination for the remainder of the services.

DOS	CPT CODE	EOB Denial Code	Reference	Rationale
8-11-03 11-25-03	99211 97110	U	IRO Decision	IRO disagrees with the insurance carrier and agrees with the treating doctor that these services on these dates of service are medically necessary.
8-13-03 thru 8-18-03 8-22-03 9-15-03 9-19-03	97110 97530			
8-20-03 9-17-03 10-21-03 10-22-03 10-24-03 12-1-03 12-4-03 12-9-03	97110			
9-8-03 10-17-03	97110 97530 97112			
9-10-03 10-14-03	99211 97110 97530 97112			

The total amount for the services that are deemed medically necessary is \$2,912.06. The total amount for the services that are deemed not medically necessary is \$3,584.01. 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.

This dispute also contained services not addressed by the IRO and will be reviewed by the Medical Review Division. On 11-9-04, 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.

Code 99211 billed for date of service 12-4-03 was denied as "Y, NL – evaluation and management services may be reported separately only if the patient's condition requires a significant separately identifiable evaluation and management service beyond the usual pre-service and post-service physician work associated with the procedure."

Neither the carrier's EOB nor the carrier's position statement identifies the usual pre-service or post-service procedure; therefore, recommend reimbursement of \$26.19.

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

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or 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 Order is applicable to dates of service 8-11-03 through 12-9-03 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 Order is hereby issued this 6th day of January 2005.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

Date: November 5, 2004

RE:

MDR Tracking #: M5-05-0112-01

IRO Certificate #: 5242

_____ 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 _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed 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 Chiropractic reviewer who has an ADL certification. The reviewer 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Table of services
- FCE reports
- Psychological evaluation
- Daily notes
- MRI report

Submitted by Respondent:

- No documentation supplied

Clinical History

According to the supplied documentation it appears that the claimant sustained an injury on ___ when an 18 wheeler he was driving ran into an overhead bridge. The claimant was originally was seen at the emergency room on the same day. The claimant reported to _____ on 04/25/2003 for an evaluation. The claimant underwent chiropractic therapy. The claimant underwent cervical and lumbar epidural steroid injections. An RME was performed at _____ on 02/23/2004 and was given a 10% whole person impairment. A letter from the treating doctor disputing the impairment rating was dated 03/10/2004 completes the supplied documentation.

Requested Service(s)

Please review and address the medical necessity of the services rendered between 08/11/2003 – 12/09/2003 including office visits, therapeutic exercises, therapeutic activities, and neuromuscular re-education.

Decision

I disagree with the insurance company and agree with the treating doctor that the services rendered on the following dates and treatment were medically necessary:

- 08/11/2003 – 99211, 97110
- 08/13/2003 – 97110, 97530
- 08/15/2003 – 97110, 97530
- 08/18/2003 – 97110, 97530
- 08/20/2003 – 97110
- 08/22/2003 – 97110, 97530
- 09/08/2003 – 97110, 97530, 97112
- 09/10/2003 – 99211, 97110, 97530, 97112
- 09/15/2003 – 97110, 97530
- 09/17/2003 – 97110
- 09/19/2003 – 97110, 97530
- 10/14/2003 – 99211, 97110, 97530, 97112
- 10/17/2003 – 97110, 97530, 97112
- 10/21/2003 – 97110
- 10/22/2003 – 97110
- 10/24/2003 – 97110
- 11/25/2003 – 99211, 97110
- 12/01/2003 – 97110
- 12/04/2003 – 97110
- 12/09/2003 – 97110

I agree with the insurance company that the remainder of services rendered were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, the claimant sustained an injury on ___ to his cervical and lumbar regions. A MRI report dated 05/05/2003 revealed the claimant had a posterolateral herniation at L3-4, a small central herniation with annular tear at L4-5 and an annular bulge at L5-S1. The claimant also had a cervical MRI which revealed a posterolateral herniation at C3-4, a protrusion at C4-5 and a reversal of the cervical curvature. The claimant underwent conservative therapy which failed. The claimant underwent lumbar and later cervical ESIs. After completion of each ESI, 2 weeks of active therapy is seen as reasonable and medically necessary. The active therapy rendered post-ESI could help increase ROM and strength therefore benefiting the claimant. At the end of each 2 week protocol, a return to a home-based exercise protocol would be reasonable. Since the claimant was undergoing a regular treatment plan, office visits billed on each and every day are not seen as reasonable. Also, a total of 4 active therapies are seen as an adequate amount of treatment each day. Therapies in excess of 4 per day are not seen as necessary in the treatment of the compensable injury. The remainder of any therapies not listed was not objectively supported and not considered appropriate in the treatment of the injury dated ____.