

MDR Tracking Number: M5-05-1017-01

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 July 9, 2005.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the issues of medical necessity. The ultrasound, office visits, and manual therapy techniques denied with U and/or V from 08-05-03 through 09-05-03 **were found** medically necessary. The IRO agrees with the previous adverse determination that the electrical stimulation, therapeutic exercises, aquatic therapy and neuromuscular re-education from 08-05-03 through 10-06-03 denied with U and/or V **were not found** medically necessary. Therefore, the requestor is not entitled to reimbursement of the 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 that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On December 15, 2004, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
08-11-03	97140(2)	\$100.00	\$0.00	F	\$67.80	Medicare Fee Schedule	In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Therefore, 97140 will be reviewed in accordance with the Medicare program reimbursement methodology per Commission Rule 134.202 (b). Recommend reimbursement in the amount of \$67.80.
08-12-03	97032	\$39.00	\$0.00	No EOB	\$20.68	Medicare Fee Schedule, Rule 133.307(e)(2)(B)	Requestor did not submit convincing evidence of carrier receipt of the providers' request for EOB's in accordance with rule 133.307(e)(2)(B). Therefore, reimbursement is not recommend.

09-26-03	97110	\$48.00	\$0.00	G	\$35.91	Medicare Fee Schedule	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.
TOTAL		\$187.00					The requestor is entitled to reimbursement of \$67.80.

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 the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and/or in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); 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 for dates of service 08-05-03 through 09-05-03 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 Order is hereby issued this 25th day of January 2005.

Patricia Rodriguez
 Medical Dispute Resolution Officer
 Medical Review Division
 PR/pr

Enclosure: IRO Decision



Specialty Independent Review Organization, Inc.

Amended Report 01/19/2005

January 7, 2005

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-05-1017-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

Mr. ___ sustained a work related injury on ___ according to the records. He apparently reported to the office of Chad Oistad, DC on 8/5/03. The injury was stated to have occurred when the patient was driving a company vehicle when he struck another vehicle, which had become apparently disabled in the roadway. His history is positive for episodic seizures prior to the year 2000. He presents with neck, left shoulder, mid back and low back pain on the level of 8/10. Cervical ROM was reduced. Lumbar ROM was not indicated and left shoulder ROM was noted to be decreased in all ROM's, but the right side was not measured as a comparative measure. The prognosis of 8/5/03 indicates "the patient's response to therapy will depend in large part on her compliance with the

recommended treatment protocol". An MRI indicates a small herniation at L4/5 with no neural impingement. He has had consultations/treatments with Jerry Keepers, MD, Richard Francis, MD, Louis Varela, MD. An FCE of 12/10/03 indicates he functions at a Medium PDL. His stated work is of a Heavy PDL. A rehab program was apparently performed from 8/5/03 through 10/6/03 according to the records received. ESI's were performed by Dr. Keepers.

Records were received from the requestor/treating doctor. The records received include the following: TWCC intake paperwork, 12/29/04 request for MDR letter, 8/5/03 initial eval report by Dr. Oistad, consultation notes by Jerry Keepers, MD (10/28/03 - 8/2/04, notes from Richard Francis MD (4/7/04 - 6/15/04), Lumbar MRI of 10/23/03, cervical radiographic report of 11/17/03, initial psychological consultation by Med-Psych Services of 8/26/03, progress report by Med-Psych of 9/9/03, FCE of 12/10/03, progression indexes (oswestry, NDI, etc), FCE of 10/9/03 and daily progress notes from 8/5/03 through 10/6/03.

Records were NOT received from the respondent. Attempts were made to obtain records via fax and phone; however, the respondent did not respond as per the deadline established by TWCC rule.

DISPUTED SERVICES

Disputed services include the following according to the TWCC 60 and table of disputed services: 99213, 97032, 97035, 99212, 97140, 97112, 97113 and 97110 from 8/5/03 through 10/6/03.

DECISION

The reviewer agrees with the previous adverse determination regarding code 97032 on all dates of service.

The reviewer disagrees with the previous adverse determination regarding 97035, 99213, 99212 and 97140, from dates of service 8/5/03 through 9/5/03.

The reviewer agrees with the previous adverse determination regarding all remaining services due to the fact they were not properly documented.

BASIS FOR THE DECISION

The reviewer indicates that the usage of an attended electrical stimulation was neither medically indicated nor necessary. A simple unattended therapy would have accomplished the same treatment goal. The reviewer indicates that the requestor did not enclose specific exercises for the dates of service that were performed by the patient; therefore, medical necessity cannot be established. Specifically, exercises were not defined, times were not included and patient responses to treatment protocols. Medicare treatment standards, Chiropractic Physiological Therapeutics and Rehabilitation Guidelines and standards of clinical practice indicate that medical necessity cannot be established without proper documentation.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations

regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director