

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. The dispute was received on 2-17-05.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 2-16-04.

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

The IRO reviewed office visits, therapeutic exercises, chiropractic manual treatment-spinal, manual therapy technique, neuromuscular reeducation, gait training, DME, supplies and materials, neuromuscular stimulator and therapeutic activities that were denied for medical necessity for 2-23-04 through 6-4-04.

The office visits, therapeutic exercises, neuromuscular reeducation and therapeutic activities from 2-23-04 through 6-4-04 were **found** to be medically necessary. The chiropractic manual treatment-spinal, manual therapy technique, gait training, DME, supplies and materials and neuromuscular stimulator from 2-23-04 through 6-4-04 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. The amount due the requestor for the medical necessity issues is \$8,396.48.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees 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 3-10-05 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 respondent responded untimely to the requestor's request for medical dispute resolution. Per Rule 133.307 (e)(3) (B) Upon receipt of the request, the respondent shall provide any missing information required on the form, including absent EOB's not submitted by the requestor with the request: and (C), file the completed request with the division and the requestor within fourteen calendar days of the respondent's receipt of the request. The MDR stamp date of this dispute is 2-17-05. The carrier responded on 3-15-05. Therefore, the services for which there was no EOB on the date that the dispute was forwarded to the IRO (3-10-05) will be reviewed per Rule 134.202 (c).

Regarding CPT code 98040-59 on 2-17-04, 2-18-04, 2-19-04, 2-20-04, 4-2-04, 4-5-04, 4-7-04, 4-8-04, 4-12-04, 4-14-04, 4-16-04, 4-30-04, 5-3-04: neither the carrier nor the requestor provided EOB's. 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). **Recommend reimbursement of \$421.85 (\$32.45 X 13 DOS).**

Regarding CPT code 97140 on 2-17-04, 2-18-04, 2-19-04 (2 units), 2-20-04 (2 units), 4-2-04, 4-5-04 (2 units), 4-7-04 (2 units), 4-8-04, 4-12-04 (2 units), 4-14-04, 4-16-04 (2 units), 4-30-04, 5-3-04: neither the carrier nor the requestor provided EOB's. 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). **Recommend reimbursement of \$625.10 (\$32.90 X 19 units).**

Regarding CPT code 97112 on 2-17-04, 2-18-04, 2-19-04, 2-20-04, 4-2-04, 4-5-04, 4-7-04, 4-8-04, 4-12-04, 4-14-04, 4-16-04, 4-30-04, 5-3-04: neither the carrier nor the requestor provided EOB's. 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). **Recommend reimbursement of \$463.58 (\$35.66 X 13 DOS).**

Regarding CPT code 97116 on 2-17-04, 2-18-04, 2-19-04, 2-20-04, 4-2-04, 4-5-04, 4-8-04, 4-14-04, 4-30-04, 5-3-04: neither the carrier nor the requestor provided EOB's. 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). **Recommend reimbursement of \$397.67 (\$30.59 X 13 DOS).**

Regarding CPT code 97110 on 2-17-04, 2-18-04, 2-19-04, 2-20-04, 4-2-04, 4-5-04, 4-7-04, and 4-8-04 (6 units on each date of service): 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 99070 on 2-17-04, 2-18-04, 2-19-04, 2-20-04, 4-2-04, 4-5-04, 4-7-04, 4-8-04, 4-12-04, 4-14-04, 4-16-04, 4-30-04, 5-3-04: neither the carrier nor the requestor provided EOB's. 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). **Recommend reimbursement of \$195.00 (\$15.00 X 13 DOS).**

Regarding CPT code 97530 on 4-12-04, 4-14-04, 4-16-04, 4-30-04 and 5-3-04 (6 units each date of service): neither the carrier nor the requestor provided EOB's. 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). **Recommend reimbursement of \$1,083.30 (\$36.11 X 30 units).**

Regarding HCPCS code E1399 on 4-5-04 (2 units) and 4-16-04: neither the carrier nor the requestor provided EOB's. 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). Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Requestor. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. **Recommend no reimbursement.**

Regarding HCPCS code E0745 on 4-8-04: neither the carrier nor the requestor provided EOB's. 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). Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Requestor. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. **Recommend no reimbursement.**

This Findings and Decision is hereby issued this 24<sup>th</sup> day of May, 2005.

Medical Dispute Resolution Officer  
Medical Review Division

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 for the unpaid medical fees totaling \$11,582.98 from 2-17-04 through 6-4-04 outlined above as follows: In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) 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 as outlined above in this dispute.

This Order is hereby issued this 24<sup>th</sup> day of May, 2005.

Director, Medical Dispute Resolution  
Medical Review Division

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

April 21, 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 #: M5-05-1712-01  
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 35 year-old male injured his back on \_\_\_\_ while assisting a resident that had fallen and was unable to get up without assistance. The patient felt a sharp pain across his low back that got progressively worse through the next hours. He now complains of pain in his low back and left leg. He has been treated with therapy, medications and surgery.

Requested Service(s)

Therapeutic exercises, chiropractic manual treatment – spinal, manual therapy technique, neuromuscular re-education, gait training, durable medical equipment, supplies and material, neuromus stimulator, office visits (99213 and 99215), therapeutic activities for dates of service 02/23/04 through 06/04/04

M5-05-1712-01

**Decision**

It is determined that there is medical necessity for the office visits (99213 and 99215), therapeutic exercises, neuromuscular re-education and therapeutic activities for dates of service 02/23/04 through 06/04/04.

It is determined that there is no medical necessity for the chiropractic manual treatment – spinal, manual therapy technique, gait training, durable medical equipment, supplies and material, and neuomus stimulator for dates of service 02/23/04 through 06/04/04.

**Rationale/Basis for Decision**

Medical record documentation indicates this patient received appropriate treatment, diagnostic testing and referrals. He required two surgical interventions for this injury and had an appropriate 4-month postoperative recovery period after the second surgery to ensure successful fusion. According to national treatment guidelines and current literature, a postoperative rehabilitation program was started. The office visits (99213 and 99215), therapeutic exercises, neuromuscular re-education and therapeutic activities were well documented, reasonable and medically necessary for the treatment of this patient's on the job injury for dates of service 02/23/04 through 06/04/04.

Medical record documentation did not; however, indicate the need of the other requested services. Therefore, the chiropractic manual treatment – spinal, manual therapy technique, gait training, durable medical equipment, supplies and material, and neuomus stimulator for dates of service 02/23/04 through 06/04/04 were not medically necessary to treat this patient's medical condition.

Sincerely,

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

GBS:dm