

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER: 453-05-7332.M5

MDR Tracking Number: M5-05-1835-01

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 03-02-05.

The IRO reviewed office visits, therapeutic exercises, physician review/interpretation analysis, manual therapy technique, electrical stimulation, muscle testing-extremity and muscle testing-whole body rendered from 08-05-04 through 10-27-04 that were denied based upon "V".

The IRO concluded that the services in dispute from 08-05-04 through 09-06-04 **were not** medically necessary and services in dispute from 09-07-04 through 10-27-04 **were** medically necessary. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$1,287.26**.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of 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 \$460.00** 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.

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 03-21-05, 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.

CPT code 99080-73 date of service 08-19-04 denied with denial code "Y/F" (Fee Guidelines MAR reduction). The carrier has not made a payment. Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation to support the services billed. Reimbursement per Rule 133.106(f)(1) is recommended in the amount of **\$15.00**.

CPT code 97110 dates of service 09-07-04, 09-14-04, 09-15-04, 09-16-04, 09-21-04, 09-24-04, 09-30-04, 10-06-04, 10-07-04, 10-11-04, 10-12-04, 10-14-04, 10-18-04, 10-19-04 and 10-21-04 denied with denial code "Y/N" (documentation does not support services). Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings 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 (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. No reimbursement is recommended.

CPT code 96004 date of service 09-16-04 denied with denial code "Y/N" (documentation does not support services). Per Rule 133.307(g)(3)(A-F) the requestor submitted documentation that supports the services billed. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$152.75 (\$122.20 X 125%)**.

CPT code 97140 date of service 09-21-04 denied with denial code "NG" (no explanation was given on the EOB submitted). Per Rule 133.304 (c) "the explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)". Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$34.13 (\$27.30 X 125%)**.

CPT code 97032 date of service 09-24-04 denied with denial code "N" (not documented). Per Rule P133.307(g)(3)(A-F) the requestor submitted documentation that supports the services billed. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$20.20 (\$16.16 X 125%)**.

### **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 for dates of service 08-19-04 through 10-27-04 totaling \$1,509.34 in accordance with the 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 Findings and Decision and Order are hereby issued this 12th day of May 2005.

Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO Decision

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity  
IRO Decision Notification Letter**

<b>Date:</b>	<b>5/10/05</b>
<b>Injured Employee:</b>	
<b>MDR #:</b>	<b>M5-05-1835-01</b>
<b>TWCC #:</b>	
<b>MCMC Certification #:</b>	<b>5294</b>

**REQUESTED SERVICES:**

Review the items in dispute regarding 99213 OV, 97110 therapeutic exercises, 96004 phys review/inter analy, 97140 manual therapy technique, G0283 elec stimulation, 95831 muscle testing-extremity, 95833 muscle testing-whole body. Denied by carrier as unnecessary treatment with peer review EOB codes "V" and "YN"

Dates of service: 08/05/2004 through 10/27/2004

**DECISION: PARTIAL**

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MCMC llc (MCMC) is an Independent Review Organization (IRO) that has been selected by The Texas Workers' Compensation Commission (TWCC) to render a recommendation regarding the medical necessity of the above disputed service.

Please be advised that a MCMC Physician Advisor has determined that your request for an M5 Retrospective Medical Dispute Resolution on 3/21/05, concerning the medical necessity of the above referenced requested service, hereby finds the following:

**The medical necessity of the array of services listed above from 08/05/2004 through 09/06/2004 is not established. However, the medical necessity of the litany of services listed above from 09/07/2004 through 10/27/2004 is established.**

**CLINICAL HISTORY:**

Records indicate that the above captioned individual was injured in a truck multiple rollover during the course of his normal employment on or about \_\_\_\_\_. The injured individual reported immediate pain in the cervical spine with right and left shoulder pain. Records indicate that he was seen in an emergency facility immediately following the accident. The injured individual then presented to several consultative entities. Treatment to date has included conservative care in the form of passive modalities, manual therapy techniques to include trigger point therapy, chiropractic manipulative treatment and medication management. An MRI of the cervical spine dated 03/18/2004 revealed a disc protrusion at C4/C5 and C5/C6. On 03/29/2004, the injured individual underwent an MRI of the right shoulder, which revealed a partial tear of the supraspinatus tendon with associated tendonopathy and degenerative changes. Electrodiagnostic findings dated 03/30/2004 revealed a right C5 radiculopathy. A

surgical consult on 04/12/2004, for the purpose of evaluation for surgery, recommended continued conservative care. This same surgical consultant opined on 05/06/2004 that surgical intervention was necessary. Surgical intervention was eventually performed on 08/23/2004 and post-surgical rehabilitation was initiated on 09/07/2004. After the course of post-surgical intervention, a course of work-hardening was initiated.

#### **RATIONALE:**

The submitted documentation contains no objective data to establish that ongoing therapeutic benefit was being accomplished through the continuing course of chiropractic care prior to 09/07/2004. However, the injured individual underwent surgery on 08/23/2004 to repair internal derangement of the shoulder and an appropriate course of surgical rehabilitation was initiated on 09/07/2004. The documentation includes a cursory exam performed on or about 09/07/2004, which reveals specific objective and subjective deficits, which medically necessitated the attended frequency and duration of care from 09/07/2004 through 10/27/2004.

#### **REFERENCES:**

ACOEM Guidelines  
The Medical Disability Advisor

#### **RECORDS REVIEWED:**

- TWCC Notification of IRO Assignment
- TWCC MR-117
- TWCC-60
- TWCC-69s
- TWCC-73s
- Cornerstone Mutual Ins. Co.: Explanation of Benefits; Health Insurance Claim forms
- The Covenant Group: Explanation of Benefits; Letter to MCMC dated 4/13/05, 4/12/05
- Summit Rehab Centers: Letter of Medical Necessity dated 3/30/05; Isometric Testing dated 10/25/04
- Article: Clinical Orthopaedic Rehabilitation
- Medconfirm: Chiropractic Peer Review Addendum dated 10/7/04, 11/12/04, 4/26/04, 5/19/04; Peer Review dated 7/9/04, 6/15/04
- DFW Pain Center: Impairment Evaluation dated 11/1/04
- McConnell Orthopedic Clinic: Operative Report dated 8/23/04
- Churchill Evaluation Centers: Report of Medical Evaluation dated 7/12/04
- David Spinks, DO: History and Physical dated 7/12/04
- Unimed Direct, LLC: Review Determinations dated 12/17/04
- Marivel C. Subia, DC: Clinical notes dated 8/5/04 to 10/27/04
- HealthSouth Evaluation Center: History and Physical dated 10/27/04
- Notice of Disputed Issues and Refusal to Pay Benefits: Undated, Adjuster: Kathleen Murphy
- Kevin White, DC: Peer Review dated 6/7/04, 5/10/04

The reviewing provider is a Licensed Chiropractor and certifies that no known conflict of interest exists between the reviewing Chiropractor and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO. The reviewing physician is on TWCC's Approved Doctor List.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5)).

**In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of TWCC on this**

**10<sup>th</sup> day of May 2005.**

**Signature of IRO Employee:** \_\_\_\_\_

**Printed Name of IRO Employee:** \_\_\_\_\_