

MDR Tracking Number: M5-05-1877-01

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 (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 3-8-05.

In accordance with Rule 133.308 (e)(1), 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: 3-1-04 through 3-5-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. 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.

The IRO reviewed office visits, therapeutic exercises, mechanical traction and manual therapy technique denied for medical necessity from 3-9-04 through 10-05-04.

The established office visit, Level III on 6-3-04 **was found** to be medically necessary. The remaining office visits, therapeutic exercises, mechanical traction and manual therapy technique, denied for medical necessity from 3-9-04 through 10-05-04 **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 \$67.25.

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 4-1-05 the Medical Review Division submitted a Notice to the 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.

Regarding CPT code 97110 on 3-9-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). 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 99080-73 on 3-22-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$15.00.**

CPT code 99080-73 on 4-21-04, 5-26-04, 6-25-04, 7-27-04 and 8-23-04 was denied as "N" – Not appropriately documented. The requestor did submit copies of this report. Therefore documentation could be verified. **Recommend reimbursement of \$75.00.**

The carrier denied CPT Code 99080-73 on 9-20-04 with a V for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requestor submitted relevant information to support delivery of service. This dispute will be referred to Compliance and Practices for violation of this rule. **Recommend reimbursement of \$15.00.**

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 totaling \$217.25 from 3-22-04 through 9-20-04 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 Decision and Order is hereby issued this 11th day of May, 2005

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

April 25, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-05-1877-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
General Counsel

GP:thh

REVIEWER'S REPORT
M5-05-1877-01

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Correspondence

Office notes 11/24/03 – 10/27/04

Physical therapy notes 11/24/03 – 10/27/04

FCE 02/08/05

Electrodiagnostic study 12/22/04

Radiology reports 10/09/03 – 10/13/03

Information provided by Respondent:

Designated doctor reviews

Information provided by Internist:

Office notes 10/10/03 – 11/06/03

Information provided by Orthopedic Surgeon:

Office notes 10/31/03 – 11/06/04

Information provided by Neurosurgeon:

Office note 01/04/05

Clinical History:

This patient is a 58-year-old female who, while working on ____, injured her lower back. She was treated initially at the emergency room, x-rayed and released. An MRI performed a couple of weeks later revealed a posterior and left paracentral disc herniation at L1-2 with moderate narrowing of the spinal canal, and degenerative disc disease at L1-2 and L4-5. After approximately 2 weeks of physical therapy, she changed to a doctor of chiropractic and began chiropractic care with physical therapy and rehabilitation. She was evaluated by a designated doctor on 5/14/04, determined not to be at MMI, and then evaluated again by the same designated doctor on 11/19/04 with the same conclusion.

Disputed Services:

Office visits, therapeutic exercises, mechanical traction, and manual therapy technique during the period of 03/09/04 thru 10/05/04.

Decision:

The reviewer partially disagrees with the determination of the insurance carrier and is of the opinion that the established office visit, level III on 06/03/04 was medically necessary. All other office visits, exercises, traction and therapy during the period in dispute were not medically necessary in this case.

Rationale:

As the treating doctor of chiropractic in this case, it was both reasonable and necessary for her to perform periodic evaluations of this patient. Therefore, the reexamination performed on 6/3/04 was supported as medically necessary.

However, in terms of the established patient office visits, level II (99212), nothing in either the diagnosis or medical records in this case supported the medical necessity of performing this level of Evaluation and Management (E/M) service routinely on each and every encounter, per CPT¹, and particularly not during an already-established treatment plan.

Insofar as the neuromuscular reeducation service (97112) was concerned, there was nothing in either the diagnosis or the physical examination findings on this patient that demonstrated the type of neuropathology that would necessitate the application of this service. According to a Medicare Medical Policy Bulletin², “This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Neuromuscular reeducation may be reasonable and necessary for impairments which affect the body’s neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity). The documentation in the medical records must clearly identify the need for these treatments.” In this case, however, gait, proprioception and neurological findings were repeatedly recorded as negative, rendering the performance of this service medically unnecessary.

With regard to the joint mobilization service (97140), mobilization has been shown to be ineffective for patients with low back pain.³

And finally, in terms of the therapeutic exercises (97110), Section 413.011, Labor Code, provides that the TWCC must use the reimbursement policies and guidelines promulgated by the Medicare system. The “Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries” Reimbursement Policies applicable to the Texas Medicare system provide as follows: “It is expected that patients undergoing rehabilitative therapy for musculoskeletal injuries in the absence of neurological compromise will transition to self-directed physical therapy within two months... Only the more refractory cases requiring additional therapy are expected to continue beyond this point and additional documentation of necessity and medical certification by the supervising physician is required.” In this case, has exceeded the recommended two months of active care established by the Medicare

¹ *CPT 2004: Physician’s Current Procedural Terminology, Fourth Edition, Revised.* (American Medical Association, Chicago, IL 1999),

² HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

³ Frost H, Lamb SE, Doll HA, Carver PT, Stewart-Brown S. Randomised controlled trial of physiotherapy compared with advice for low back pain.

BMJ. 2004 Sep 25;329(7468):708. Epub 2004 Sep 17.

Reimbursement Policies. Since no documentation was submitted establishing either (a) objective proof of neurological compromise; or (b) that this is a refractory case, the medical necessity of the treatment cannot be supported. The records demonstrate that the patient had already been participating in a supervised rehabilitation program for greater than two months before these dates in dispute even began. Without documentation to the contrary, the patient should have been more than capable of performing her rehabilitation in a home setting by 3/9/04, particularly when current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises."⁴ Furthermore, any gains obtained in this time period would have likely been achieved through performance of a home program.

⁴ Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.