

**TEXAS WORKERS' COMPENSATION COMMISSION  
MEDICAL REVIEW DIVISION, MS-48  
MEDICAL DISPUTE RESOLUTION  
FINDINGS AND DECISION**

**Dr. Julio Santiago, D. C.**  
1150 W. Kiest Blvd. Ste 400-C  
Dallas, Texas 75224

**Requestor**

**V.**

**Rochdale Insurance Company, Box 17**

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**MDR TRACKING #: M5-05-1990-01**

**TWCC FILE #:**

**CLAIMANT:**

**DOI:**

**SERVICE FROM: 10-25-04**

**SERVICE TO: 12-22-04**

**Respondent**

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**Si prefiere hablar con una persona de habla hispana acerca de esta correspondencia sirvase llamar al 1-512-804-4812.**

The Medical Review Division reviewed the decision of the Independent Review Organization (IRO) in the captioned medical dispute and concludes the dispute with the enclosed Decision and Order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you **5** (five) days after it was mailed and the first working day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision and Order shall deliver a copy of this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Decision and Order was placed in the insurance carrier representative's box and mailed to the requestor applicable to Commission Rule 102.5 this \_\_\_\_\_ day of \_\_\_\_\_ 2005. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision and Order was placed in the carrier representative's box.

Signature of Commission Employee: \_\_\_\_\_

Printed Name of Commission Employee: \_\_\_\_\_

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 3-16-05.

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.

Two units of therapeutic exercises per date of service from 10-25-04 through 11-19-04 and the office visit on 10-25-04 **were found** to be medically necessary. The therapeutic exercises from 11-29-04 through 12-22-04, office visits from 10-27-04 through 12-22-04, prolonged physical services, neuromuscular reeducation, therapeutic activities, massage and electrical stimulation from 10-25-04 through 12-22-04 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge. Therefore, the reimbursement for the office visits will be \$103.24. The amount due the requestor for the medical necessity issues is \$917.02.

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.

The carrier denied CPT Code 99080-73-RR 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. Per Rule 129.5 (2) "CPT code "99080" with modifiers "73" and "RR" (for "requested report") shall be used when the doctor is billing for an additional report requested by or through the carrier under subsection (d)(3) of this section." **Recommend reimbursement of \$15.00.**

CPT code 97110 on 11-17-04 was denied by the carrier as "N – not documented." 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.**

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 \$932.02 from 10-25-04 through 11-19-04 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 6<sup>th</sup> day of May, 2005.

Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO decision

**IRI**

April 25, 2005

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

Re: Medical Dispute Resolution  
MDR #: M5-05-1990-01  
TWCC#:  
Injured Employee:  
DOI:

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**  
**M5-05-1990-01**

**Information Provided for Review:**

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

Information provided by Requestor:

Correspondence

Office note 10/25/04

Physical therapy notes 10/04/04 – 01/26/05

Information provided by Respondent:

Correspondence

Designated doctor reviews

Information provided by Orthopedic Surgeon:

Office notes 08/05/03 – 12/16/04

Occupational therapy notes 10/14/04 – 10/21/04

Procedure notes 09/23/04 – 12/16/04

**Clinical History:**

This male patient underwent physical medicine treatments, splinting, cortisone injections, work hardening and surgeries after sustaining a work-related puncture wound to his right hand on

**Disputed Services:**

Prolonged physical service, therapeutic exercises, office visits, neuromuscular re-education, therapeutic activities, massage therapy, and electrical stimulation during the period of 10/25/04 thru 12/22/04.

**Decision:**

The reviewer partially agrees with the determination of the insurance carrier as follows:

Medically Necessary:

Therapeutic exercises (97110) – 2 units per date of service during the 4-week period from 10/25/04 thru 11/19/04.

Post-surgical evaluation office visit (99214) on 10/25/04.

Not Medically Necessary:

All other treatment, examinations, procedures and services in dispute curing the period of 10/25/04 thru 12/22/04.

**Rationale:**

Physical medicine is an accepted part of a rehabilitation program following surgery. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include: (A) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (B) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (C) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (D) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment.

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. In this case, there is no documentation of objective or functional improvement in this patient's condition and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment. In fact, no re-examination was ever performed. Therefore, solely on the basis that surgery was performed, a maximum of 2 units of therapeutic exercises (97110) per date of service during the 4-week period from 10/25/04 through 11/19/04 are approved. The post surgical evaluation (99214) on 10/25/04 is also approved.

Therapeutic exercises and therapeutic activities may be performed in a clinic one-on-one, in a clinic in a group, at a gym or at home with the least costly of these options being a home program. A home exercise program is also preferable because the patient can perform them on a daily basis. On the most basic level, the provider has failed to establish why the continuing services were required to be performed one-on-one after 11/19/04 when current medical literature states, "...there is no strong evidence for the effectiveness of supervised

training as compared to home exercises.”<sup>1</sup> Services that do not require “hands-on care” or supervision of a health care provider are not considered medically necessary services even if the services are performed by a health care provider. Moreover, after previously undergoing a work hardening program and 4 weeks of monitored instruction, the claimant would have certainly been able to perform the exercises and therapeutic activities after 11/19/04.

Based on CPT<sup>2</sup>, there is no support for the medical necessity for prolonged physical service (99354) or the 99213 office visits during an established treatment plan...and certainly not on nearly every date of service.

It is the position of the Texas Chiropractic Association<sup>3</sup> that it is beneficial to proceed to the rehabilitation phase (if warranted) as rapidly as possible, and to minimize dependency upon passive forms of treatment/care since studies have shown a clear relationship between prolonged restricted activity and the risk of failure in returning to pre-injury status. The TCA Guidelines also state that repeated use of acute care measures generally fosters chronicity, physician dependence and over-utilization and the repeated use of passive treatment/care tends to promote physician dependence and chronicity. Therefore, the medical necessity for massage therapy (97124) and electrical stimulation (G0283) is not supported.

In regard to neuromuscular re-education (97112), its medical necessity was not supported by the medical records submitted. Specifically, 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 97112 neuromuscular re-education. According to a Medicare Medical Policy Bulletin<sup>4</sup>, “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.”

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<sup>1</sup> 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.

<sup>2</sup> CPT 2004: *Physician’s Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),

<sup>3</sup> Quality Assurance Guidelines, Texas Chiropractic Association.

<sup>4</sup> HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)