THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: 453-05-7890.M5

MDR Tracking Number: M5-05-2110-01

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 3-29-05.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if they are 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: 3-24-05 through 3-25-05.

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.

The IRO reviewed mechanical traction, therapeutic exercise, group therapeutic procedures, massage therapy, muscle testing, office visits, chiropractic manipulative treatment-spinal and DME from 3-29-04 through 10-12-04.

The mechanical traction, therapeutic exercise, group therapeutic procedures, massage therapy, muscle testing, office visits, chiropractic manipulative treatment-spinal and DME from 3-29-04 through 4-19-04 **were found** to be medically necessary. The mechanical traction, therapeutic exercise, group therapeutic procedures, massage therapy, muscle testing, office visits, chiropractic manipulative treatment-spinal and DME from 4-20-04 through 10-12-04 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. Since there were no services denied for medical necessity from 3-29-04 through 4-19-04, there is no reimbursement for medical necessity issues.

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 5-19-05 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.

CPT code 97139-EU on 3-29-04, 3-30-04, 3-31-004, 4-14-04, 4-30-04, 5-3-04, 5-5-04, 5-14-04, 5-17-04, 5-18-04, 5-24-04, 6-2-04, 6-3-04, 6-7-04, 6-10-04, 6-11-04, 6-15-04, 6-23-04, 6-24-05, 6-29-04, 7-6-04 and 8-10-04 was denied by the carrier as "B290 – The

modifier billed is not valid for this date of service." Per Ingenix Encoder Pro "EU" is not a valid modifer for this service. **Recommend no reimbursement.**

CPT code 95851 on 4-6-04 (3 units) and 8-12-04 (3 units) was denied as "This procedure is incidental to the related primary procedure billed." Per Ingenix Encoder Pro CPT code 95851 is considered by Medicare to be a component procedure of the 97750. However, the requestor never reimbursed the requestor for CPT code 97750. **Recommend reimbursement of $183.60 (30. 60 X 6 units).**

CPT code 97750-MT on 4-6-04, 4-8-04, 8-12-04, 8-13-04 ; was denied by the insurance carrier. Per Ingenix Encoder Pro the modifier "MT" is not a valid modifier. **Recommend no reimbursement.**

CPT code 98941 on 4-14-04, 7-6-04, 7-13-04; was either denied as "This procedure will be reevaluated upon receipt of the proper code/modifier." or no EOB's were sent by either the Requestor or the Respondent. Per Ingenix Encoder Pro this is a valid CPT code. **Recommend reimbursement of $125.64 ($41.88 X 3 DOS).**

Regarding CPT code 97110 on 5-4-04, 7-6-04, 7-9-04, 7-13-047-26-04, was either denied as "Z560-the charge for this service exceeds the fee schedule" or no EOB's were received from either the requestor or the respondent. 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. **Additional reimbursement not recommended.**

CPT code 99080 on 5-10-04 was denied as "X212-this procedure is included on another procedure on this date." However no other services were performed on this date**. Recommend reimbursement of $46.00.**

Regarding CPT code 99080 on 7-2-04: 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 $72.50.**

Regarding CPT code 99212-25 on 7-6-04, 7-13-04: 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 $83.82. ($41.91 X 2 DOS).**

Regarding CPT code 97012 on 7-6-04, 7-7-04, 7-9-04, 7-13-04 and 7-26-04: 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 $86.00 ($17.20 X 5 DOS).**

Regarding CPT code 97150 on 7-6-04, 7-9-04, 7-13-04 and 7-28-04: 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 $85.48 ($21.37 X 4 DOS).**

Regarding CPT code 97124 on 7-6-04, 7-7-04, 7-9-04, 7-13-04 and 7-26-04: 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 $128.45 ($25.69 X 5 DOS).**

Regarding CPT code 99213-25 on 7-7-04, 7-26-04, : 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 $117.98 ($58.99 X 2 DOS).**

Regarding CPT code 99211 on 7-7-04: 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 $23.35.**

Regarding CPT code 99212 on 7-23-04 was denied as "U687 – This procedure is mutually exclusive to another on this date of service." The "other service" performed on this date was a review of the 99455 report. The doctor solely reviewed this report. He did no examination. **Recommend reimbursement of $41.91.**

Regarding CPT code 97150 on 7-23-04, 7-26-04 and 7-30-04 was denied as "U-027 – reimbursement is reduced by the mount previously paid for another code mutually exclusive to this procedure." Per Ingenix Encoder Pro CPT code 97150 is considered by Medicare to be a mutually exclusive procedure of CPT code 97110 and 97124. **Recommend no additional reimbursement.**

Regarding CPT code 98940 on 7-26-04: 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 $30.13.**

Regarding CPT code 99080-73 on 9-27-04, 9-28-04, 10-04-04: The carrier denied CPT Code 99080-73 with a "V" for unnecessary medical treatment based on a peer review; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. A referral will be made to Compliance and Practices for this violation of the Rule. The Medical Review Division has jurisdiction in this matter. **Recommend reimbursement of $45.00 ($15.00 X 3 DOS).**

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 $1,069.86 from 4-6-040 through 10-04-004 in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order.

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 Decision and Order is hereby issued this 20th day of June 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

June 16, 2005
June 9, 2005

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

REVISED REPORT

Re: Medical Dispute Resolution
MDR #: M5-05-2110-01
TWCC#:
Injured Employee: ___
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear ___:

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
M5-05-2110-01

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
Correspondence

Office notes 03/19/04 – 08/12/04
Daily progress notes 03/19/04 – 01/18/05
Therapeutic procedures 03/25/04 – 07/30/04
Range of motion testing 03/25/04 – 08/12/04
Radiology report 04/06/04
Information from Respondent:
Designated doctor review
Information from Rehabilitation Medicine
Office note 03/03/04
Information from Neurologist:
Office note 05/11/04
Information from Orthopedist:
Office note 08/23/04

Clinical History:
This male patient underwent examinations and physical medicine treatments after sustaining injury at work on ___.

Disputed Services:
Mechanical traction, therapeutic exercises, group therapeutic procedures, massage therapy, muscle testing, office visits, chiropractic manipulative treatment-spinal 3-to-4 regions and DME.

Decision:
The reviewer partially agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were medically

necessary through 04/19/04. These treatments, services and DME beyond 04/19/04 were not medically necessary in this case.

Rationale:
The *Guidelines for Chiropractic Quality Assurance and Practice Parameters* [1] Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Therefore, the medical necessity for the treatment from the initiation of care through 04/19/04 is supported.

Since there was no "significant documented improvement" during this 4-week time period, all treatment after 04/19/04 is denied. In fact, the medical records fail to substantiate that the aforementioned services fulfilled the statutory requirements [2] since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to employment. Specifically, his pain ratings remained essentially unchanged from 03/19/04 (6/10) until as late as 09/30/04 (5/10) and the claimant's ranges of motion had no significant improvement from 04/06/04 to 08/12/04. Without question, any small gains after 04/19/04 would have likely been achieved through performance of a home exercise program.

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[1] Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Aspen Publishers, Inc.
[2] Texas Labor Code 408.021