

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> ( ) Yes (X) No
Requestor's Name and Address South Coast Spine and Rehab, P. A. 620 Paredes Line Road Brownsville, TX 78521	MDR Tracking No.: M5-05-2171-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address  Texas Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
11-8-04	1-20-05	CPT codes 97113, 97032, 97124, 97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
11-8-04	1-20-05	CPT code 97035	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

### PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues.

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. The aquatic training, electrical stimulation, massage therapy and therapeutic exercises rendered from 11-8-04 through 1-20-05 were found to be medically necessary. Ultrasound rendered from 11-8-04 through 1-20-05 was not found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 5-6-05 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 97110 on 12-15-04 was denied by the carrier as "790 – This charge was reduced in accordance to the Texas Medical Fee Guideline." 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.**

**PART IV: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$3,162.09, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

6-24-05

Ordered by:

6-24-05

Authorized Signature

Typed Name

Date of Order

**PART V: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_

**PART VI: 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 a 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 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, 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 shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

## NOTICE OF INDEPENDENT REVIEW DECISION

June 22, 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 #: M5-05-2171-01  
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 patient injured his back on \_\_\_ while installing a heavy door with a co-worker. The co-worker let go of the weight and the patient was left to hold up the door and frame. He felt pain but continued to work. Later that day he needed assistance to get off a forklift because of the pain. He has been treated with medication and therapy.

### Requested Service(s)

Aquatic training, electrical stimulation, massage therapy, ultrasound, therapeutic exercises for dates of service 11/08/04 through 01/20/05.

### Decision

It is determined that there is medical necessity for the aquatic training, electrical stimulation, massage therapy, and therapeutic exercises for dates of service 11/08/04 through 01/20/05. However, there is no medical necessity for the ultrasound for dates of service 11/08/04 through 01/20/05 to treat this patient's medical condition.

## Rationale/Basis for Decision

Medical record documentation indicates this patient underwent a lumbar laminectomy and fusion at levels L4-L5 and L5-S1 with instrumentation after a failed trial of conservative care. He received several weeks of aggressive post surgical rehabilitation. Medical record documentation indicates sufficient justification of medical necessary for all aquatic training, electrical stimulation, massage therapy, and therapeutic exercises for dates of service 11/08/04 through 01/20/05. However, current standards of care contraindicate ultrasound treatments for patients that have undergone instrumentation surgery. Therefore, the ultrasound treatments for dates of service 11/08/04 through 01/20/05 were not medically necessary to treat this patient's medical condition.

Sincerely,

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

GBS:dm

## **Information Submitted to TMF for TWCC Review**

**Patient Name:**

**TWCC ID #: M5-05-2171-01**

### **Information Submitted by Requestor:**

- **Progress Notes**
- **Impairment Rating**
- **Diagnostic Tests**

### **Information Submitted by Respondent:**

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