

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address SICEM 3103 Eisenhower Rd. #K-14 San Antonio, TX 78209	MDR Tracking No.: M5-05-2197-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Amcomp Assurance Corporation, Box 34	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ISSUES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
4-5-04	5-19-04	CPT codes 97112, 97140, 97150, 97110, 97113	<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.

In a letter dated 5-16-05 the requestor withdrew dates of service 7-26-04 through 9-30-04. These services will not be a part of this review.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail 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 services, rendered were found were 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 4-29-05 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.

Regarding dates of service 4-5-04 through 4-16-04: Neither the carrier nor the requestor provided EOB's. The respondent stated in its response received 4-26-05 that the "previous denials will stand." Respondent did not provide EOB's per rule 133.307(e)(3)(B). Reimbursement will be according to the Medicare Fee Schedule. **Reimbursement recommended as follows:**

CPT code 97110: Neither the carrier nor the requestor provided EOB's. The respondent stated in its response received 4-26-05 that the "previous denials will stand." Respondent did not provide EOB's per rule 133.307(e)(3)(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 97112 on 4-5-04, 4-7-04, 4-9-04, 4-12-04, 4-14-04 and 4-16-04: "CPT code 97112 is considered by Medicare to be a mutually exclusive procedure of CPT code 97150 (which was billed on this date of service). A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately." The requestor attached no modifier to these services. **No reimbursement recommended.**

Regarding CPT code 97140 on 4-5-04, 4-7-04, 4-9-04, 4-12-04, 4-14-04 and 4-16-04: "CPT code 97140 is considered by Medicare to be a mutually exclusive procedure of CPT code 97150 (which was billed on this date of service). A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately." The requestor attached no modifier to these services. **No reimbursement recommended.**

CPT code 97150 (6 dates of service): \$123.72

CPT code 97140 on 4-6-04, 4-8-04, 4-13-04, 4-15-04: (\$28.82 X 4 DOS) - \$115.28

CPT code 97113 on 4-6-04, 4-8-04, 4-13-04, 4-15-04: (\$33.67 X 4 DOS). - \$134.68

CPT code 97112 on 4-6-04, 4-8-04, 4-13-04, 4-15-04: (\$32.08 X 4 DOS) - \$128.32

CPT code 97112 on 4-19-04 and 4-21-04 was denied by the carrier as "R88 – Mutually Exclusive Procedures". Per Rule 133.304 (c) Carrier didn't specify which service this was global to, therefore it will be reviewed according to the Medicare Fee Schedule. **Recommend reimbursement of \$64.16.**

CPT code 97140 on 4-19-04 and 4-21-04 was denied by the carrier as "R88 – Mutually Exclusive Procedures". Per Rule 133.304 (c) Carrier didn't specify which service this was global to, therefore it will be reviewed according to the Medicare Fee Schedule. **Recommend reimbursement of \$57.64 (\$28.82 X 2 DOS).**

Regarding CPT code 97110 from 4-19-04 through 4-22-04: These services were denied by the carrier as "F – Fee Guideline MAR Reduction." 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.**

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute consistent with the applicable fee guidelines totaling \$623.80, 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:

	Donna Auby	7-25-05
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 en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

July 20, 2005

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

Re: Medical Dispute Resolution
MDR #: M5-05-2197-01
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 board certified in Physical Medicine and Rehabilitation, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
General Counsel

GP:thh

REVIEWER'S REPORT
M5-05-2197-01

Information Provided for Review:

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

Information provided by Requestor:

Correspondence

Physical therapy notes 03/31/04 – 10/01/04

FCE 04/08/04

Radiology reports 11/26/04 – 12/11/03

Information provided by Respondent:

Correspondence

Designated doctor review

Information provided by Treating Doctor:

Office notes 12/05/03 – 01/05/05

Information provided by Chiropractor:

Office note 09/14/04

Information provided by Neurosurgeon:

Office note 04/13/04

Clinical History:

This male claimant sustained a twisting injury to his low back on ___ when he attempted to maneuver an approximately 75 pound metal bracket from an overhead position and reported low back pain and right lower extremity numbness. The claimant reported continued low back pain with lifting and bending. The record documents that the patient had completed “extensive rehabilitation” prior to the program of work conditioning.

Disputed Services:

Neuromuscular re-education, manual therapy technique, group therapeutic procedures, therapeutic exercises, aquatic therapy during the period of 04/05/04 thru 05/19/04.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and procedures in dispute as stated above were not medically necessary in this case.

Rationale:

Documentation provided by the requestor was complete enough to form a medical opinion of the care denied. There does not appear to be significant medical justification for exercise, work hardening, multidisciplinary pain treatment program, physical conditioning program, exercise, or back re-education in an individual with chronic low back pain.

Systemic review of randomized controlled trials that compared multidisciplinary treatment versus controlled treatment found no significant difference between less intensive outpatient multidisciplinary treatment and multidisciplinary outpatient treatment or usual care and/or function. An additional randomized controlled trial compared extensive multidisciplinary treatment, light multidisciplinary treatment, and the usual care found no significant difference in the outcome of these. The use of back schools and re-education has 2 systemic reviews with 32 randomized controlled trials that found that back school significantly increased pain relief after 3 months compared with no treatment or other treatment, but found no difference in the outcome in the long term. Review of the physical conditioning programs found no significant difference between physical conditioning programs and generalized practitioner advice or care in the proportion of people off work at 12 months. Multiple randomized controlled trials found no significant difference between strengthening exercises or other types of exercise with regard to outcomes and conflicting evidence of strengthening exercises compared to inactive treatment. Each of these reviews supports the notion that this type of intervention in the chronic low back pain patient is not medically justified.

SCREENING CRITERIA/TREATMENT GUIDELINES/PUBLICATIONS UTILIZED:

1. van Turlter, M. and Koes, B., *Back Pain and Sciatica, (Chronic)*, Clinical Evidence 2004, 11: 1461-1533.
2. Schonstaine, E., Kenny, C., Keating, J., Koes, B.W., *Work Conditioning, Work Hardening, and Functional Restoration with Workers with Back and Neck Pain*. The Cochran Library, Issue 1, 2003.
3. Maler-Riehle, B., Harter, M., *The Effects of Back Schools: A Meta-Analysis*. International Journal of Rehabilitation Research, 2001; 24:199-206.
4. van Turlter, M.W., Esmall, R., Bombardier, V., et al: *Back Schools for Nonspecific Low Back Pain*. The Cochran Library, Issue 1, 2003.
5. Guzman, J., Esmall, R., Karjalainen, K., et al, *Multidisciplinary Rehabilitation of Chronic Low Back Pain, Systemic Review*. British Medical Journal, 2001; 322:1511-1516.
6. Skowen, J.S., Grastal, A.L., Haldorsen, E.M.H., et al: *Relative Cost Effectiveness of Expensive and Light Multidisciplinary Treatment Programs Versus Treatment as Usual for Patients with Chronic Low Back Pain on Long-Term Sick Leave*. Spine, 2002; 27:901-910.