MDR Tracking Number: M5-03-0540-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The IRO reviewed chiropractic treatment rendered from 11-14-01 to 12-31-01 that were denied based upon "U" or "V".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
11-14-01 11-16-01 11-19-01 11-20-01 11-21-01	A4558	$23.00	$0.00	U	$13.00	Section 408.021(a)	IRO concluded these services were medically necessary; therefore reimbursement of 5 X $13.00 = $65.00 is recommended.
TOTAL		$65.00					The requestor is entitled to reimbursement of **$65.00.**

The IRO's report incorrectly addressed the medical necessity of treatments that were denied by EOB denial code "A," "F," and "G". The above recommendation for payment was for services found medically necessary that were denied based upon "U."

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Consequently, the commission has determined that **the requestor did not prevail** on the majority of the medical fees ($65.00). Consequently, the requestor is not owed a refund of the paid IRO fee.

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.

On 2-12-03, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
11-13-01	97032 97010	$66.00 $17.00	$0.00	A	$22.00/15 min $11.00	Rule 134.600(h)(10)	Preauthorization was not obtained; therefore, reimbursement is not recommended.
11-14-01	97530 97110 97032 97035 97010	$49.00 $51.00 $66.00 $32.00 $17.00	$0.00	A	$35.00 $35.00/15 min $ $22.00 $11.00		
11-16-01	97010 97110 97032 97035	$17.00 $51.00 $66.00 $32.00	$0.00	A	$11.00 $35.00/15 min $22.00/15 min $22.00/15 min		
11-19-01 11-20-01	97010 97110 97032 97035	$17.00 $102.00 $66.00 $32.00	$0.00	A	$11.00 $35.00/15 min $22.00/15 min $22.00/15 min		
11-21-01	97010 97110 97032 97035	$17.00 $153.00 $66.00 $32.00	$0.00	A	$11.00 $35.00/15 min $22.00/15 min $22.00/15 min		
11-27-01	97010 97110 97032 97035	$17.00 $153.00 $66.00 $32.00	$0.00	U	$11.00 $35.00/15 min $22.00/15 min $22.00/15 min	Rule 133.301(a) Rule 133.307(g)(3)	The insurance carrier incorrectly denied preauthorized treatment. On 11-26-01, the insurance carrier gave preauthorization for 12 sessions of physical therapy. Medical records to support billed service, reimbursement is not recommended.
11-28-01 11-29-01 11-30-01 12-3-01 12-5-01 12-7-01 12-10-01 12-12-01 12-14-01 12-17-01 12-18-01 12-21-01	97110	$153.00 $153.00 $204.00 $204.00 $204.00 $204.00 $204.00 $204.00 $255.00 $255.00 $255.00 $204.00	$0.00	T	$35.00/15 min		
11-30-01 12-3-01 12-5-01 12-7-01 12-10-01 12-12-01 12-14-01	A4558	$23.00	$0.00	G	$13.00	Rule 133.307(g)(3)	Medical records to support billed service, reimbursement is not recommended.

12-14-01 12-17-01 12-18-01 12-21-01 12-26-01 12-27-01 12-28-01 12-31-01	97032	$66.00	$0.00	F	$22.00/15 min	Rule 133.307(g)(3)	Medical records to support billed service, reimbursement is not recommended.
12-14-01 12-17-01 12-18-01	97035	$32.00	$0.00	F	$22.00/15 min	Rule 133.307(g)(3)	Medical records to support billed service, reimbursement is not recommended.
12-14-01 12-17-01 12-18-01 12-21-01 12-26-01 12-27-01 12-28-01 12-31-01	97010	$17.00	$0.00	F	$11.00	Rule 133.307(g)(3)	Medical records to support billed service, reimbursement is not recommended.
12-18-01	99070	$23.00	$0.00	G	$13.00	Rule 133.307(g)(3)	Medical records to support billed service, reimbursement is not recommended.
12-26-01 12-27-01 12-28-01 12-31-01	97110	$204.00	$0.00	T	$35.00 / 15 min	Rule 133.307(g)(3)	Medical records to support billed service, reimbursement is not recommended.
12-31-01	99213	$72.00	$0.00	F	$48.00	Rule 133.307(g)(3)	Medical records to support billed service, reimbursement is not recommended.
TOTAL							The requestor is not entitled to reimbursement .

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay $65.00 plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 11/14/01 through 12/31/01 in this dispute.

This Order is hereby issued this 29th day of July 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: December 12, 2002

Requester/ Respondent Address: Rosalinda Lopez
TWCC
4000 South IH-35, MS-48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-0540-01
IRO Certificate #: 5242

___ 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 ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed 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 an orthopedic surgeon physician reviewer who is board certified in orthopedic surgery. The orthopedic surgeon physician reviewer 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 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 individual developed neck pain and after extensive conservative treatment and she underwent cervical fusion surgery. The fusion surgery was done on September 20, 2001. Subsequently, physical therapy was requested. The patient underwent physical therapy from November 13, 2001 through December 31, 2001, at one facility.

Requested Service(s)

I am requested to comment on the appropriateness of the physical therapy.

Decision

I agree that the physical therapy was either unnecessary or it was excessive, to a large extent. Most of it, in my opinion, was unnecessary. The following is a table of what therapy I consider as reasonable and necessary. In some cases, multiple units are billed under the same code in a single day. As the table says, only one unit of a given modality is ever considered as reasonable and necessary on any given day.

	Each CPT code represents a single unit of approved treatment. Where multiple units are billed under the same code, only the first is considered as medically necessary	
Date\Service	**Medically Necessary**	**Not Medically Necessary**
11/13/01	97032, 97010	
11/14/01	97530, 97110, 97032, 97010, A4558	97035
11/16/01	97032, 97110, A4558, 97010, 97032	
11/19/01	97110, 97032, A4558, 97010	97035
11/20/01	97035, A4558, 97010	97110, 97032
11/21/01	97010, 97035, A4558	97110, 97032
11/27/01	97035, 97010	97110
11/28/01	97110	
11/29/01		97110
11/30/01		A4558, 97110
12/3/01	97110	A4558
12/5/01		97110, A4558
12/7/01	97110	A4558
12/10/01	97110	A4558
12/12/01		97110, A4558
12/14/01	97035, A4558, 97010	97110, 97032
	No supervised PT after 12/14/01 is considered medically necessary	

Rationale/Basis for Decision

I have reviewed all the services, and I consider that the extent of the services was totally unjustified. I perform cervical spine surgeries, and rarely is physical therapy indicated for patient after cervical fusion. If physical therapy is requested, then the appropriate period would be four weeks, at maximum for sessions per week. The scope of services does not have to be as extensive as it is listed in the billing. I see here that on December 7th, therapeutic exercises are billed multiple times. That, in my opinion, is not necessary. This is being billed continuously on other visits. This, in my opinion, is not necessary. In addition, in my opinion, the multiple electrical stimulation was not necessary. Multiple ultrasound therapy, in my opinion, was not necessary. Just from looking at it and evaluating the total bill, I would say that twenty percent of the services you could justify if you stretch the whole thing. Anything above that, in my opinion, is totally unnecessary.

Based on my experience, education, and training with patients after cervical fusion surgery, this type of extensive and multiple therapeutic modalities is not necessary. A lot of these appear to be just therapeutic exercise, which is a supervisory type of service that does not have to be multiple. Getting the patient through post operative period requires the patient to assume their responsibility for the therapeutic exercises, and it does not take multiple, multiple occasions to supervise therapeutic exercises. Definitely, the patient had cervical fusion, thusly and from the medical records, it appears the patient had cervical fusion, thusly no manipulative treatment was indicated and therapeutic exercises performed on a patient after cervical fusion are not to the extent that they need to be supervised on multiple occasions per supervisory session. So, in my opinion, this is not justified charge along with other charges as I mentioned. A home exercise program should have been utilized in conjunction with supervised physical therapy.

This decision by the IRO is deemed to be a TWCC decision and order.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 18th day of December 2002.