MDR Tracking Number: M5-03-1452-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 2-11-03.

The IRO reviewed chiropractic treatment rendered from 7-8-02 through 9-27-02 that were denied based upon “V”.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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

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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On May 30, 2003, 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:

On 5-20-02 the TWCC approved the claimant’s request to change treating doctors to Dr. ___. The insurance carrier noted in their response that, “Although the commission approved the Claimant’s change in treating doctors, the Carrier disputed this change. This issue has been actively disputed and a BRC is currently set for 7/15/03 to decide this issue as well as disability.”

Per Rule 126.9(h), “The Commission may, after holding a benefit contested case hearing as provided by Chapter 142 of this tilted (relating to Benefit Contested Case Hearing), relieve the carrier of liability for health care furnished by a doctor or health care provider at the doctor’s direction if: 1) the doctor chosen by the employee is not on the list at the time the medical treatments or services are rendered; or 2) the employee failed to comply with Commission rules regarding a change in treating doctor.” The Benefit Contested Case Hearing found in favor of the carrier and relieved carrier of liability for health care furnished by doctor; therefore, services denied based upon “K” are dismissed and will not be considered further due to lack of jurisdiction.

Neither party submitted EOBs to identify the carrier’s rationale for reimbursement, resolution or denial of payment for services identified as “No EOB”; therefore, they will be reviewed in accordance with the *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
5-29-02	99204	$106.00	$0.00	K, F	$106.00	Evaluation & Management GR (IV) Rule 126.9	Per Rule 126.9, carrier is not liable for payment.
5-29-02	72114WP	$120.00	$0.00	K, F	$120.00	Rule 126.9	
6-3-02	99213	$48.00	$0.00	K, F	$48.00	Rule 126.9	
6-4-02	99080-73	$15.00	$0.00	K, F	$15.00	Rule 126.9	
6-10-02 6-12-02 6-14-02 6-17-02 6-19-02 6-21-02 6-24-02 6-26-02 6-28-02 7-15-02 7-26-02 8-2-02 8-9-02 8-16-02 8-23-02	99213MP	$48.00	$0.00	K, F	$48.00	Medicine GR (I)(B)(1)(b) Rule 126.9	
6-10-02 6-12-02 6-14-02 6-17-02 6-19-02 6-21-02 6-24-02 6-26-02 6-28-02	97265	$43.00	$0.00	K, F	$43.00	CPT Code Descriptor Rule 126.9	
6-10-02 6-12-02 6-14-02 6-17-02 6-19-02 6-21-02 6-24-02 6-26-02 6-28-02	97250	$43.00	$0.00	K, F	$43.00	CPT Code Descriptor Rule 126.9	
6-10-02 6-12-02 6-14-02 6-17-02 6-19-02 6-21-02 6-24-02	97122	$35.00	$0.00	K, F	$35.00	CPT Code Descriptor Rule 126.9	Per Rule 126.9, carrier is not liable for payment.

6-26-02 6-28-02							
6-10-02 6-26-02 6-28-02	97750MT	$43.00	$0.00	K, F	$43.00/ body area	Medicine GR (I)(E)(3) Rule 126.9	Per Rule 126.9, carrier is not liable for payment.
6-10-02 6-12-02 6-14-02 6-17-02 6-19-02 6-28-02	97110 (X4)	$140.00	$0.00	K, F	$35.00 / 15 min	Medicine GR (I)(A)(9)(b) Rule 126.9	
6-14-02	95851	$36.00	$0.00	K, F	$36.00	Medicine GR (I)(E)(4) Rule 126.9	
7-3-02	99213MP	$48.00	$0.00	No EOB	$48.00	Medicine GR (I)(B)(1)(b)	SOAP notes do not support a manipulation was performed to support billing in accordance with MFG; therefore, no reimbursement is recommended.
7-3-02	97265	$43.00	$0.00	No EOB	$43.00	CPT Code Descriptor	SOAP note supports service was performed to support billing in accordance with MFG; therefore, reimbursement is recommended of $43.00.
7-3-02	97250	$43.00	$0.00	No EOB	$43.00	CPT Code Descriptor	SOAP note supports service was performed to support billing in accordance with MFG; therefore, reimbursement is recommended of $43.00.
7-3-02	97122	$35.00	$0.00	No EOB	$35.00	CPT Code Descriptor	SOAP note supports service was performed to support billing in accordance with MFG; therefore, reimbursement is recommended of $35.00.
7-3-02	97110 (X4)	$140.00	$0.00	No EOB	$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	See rationale below; therefore, no reimbursement is recommended.
TOTAL							The requestor is entitled to reimbursement of **$121.00.**

Rationale for 97110:

Recent review of disputes involving one-on-one 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 therapy notes for these dates of service do not support any clinical (mental or physical) reason as to why the patient could not have performed these exercises in a group setting, with supervision, as opposed to one-to-one therapy. The Requestor has failed to submit documentation to support reimbursement in accordance with the 1996 MFG and 133.307(g)(3). Therefore, reimbursement is not recommended.

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees 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. This Decision is applicable for dates of service 5-29-02 through 9-27-02 in this dispute.

This Decision and Order is hereby issued this 6th day of August 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

May 2, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1452-01
IRO Certificate #: 5348

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 42 year-old male who sustained a work related injury on ___. The patient reported that while at work as an electrician, he was moving a bag of refuse from his electrical work. While lifting the bag it slipped causing him to catch the bag. The patient reported experiencing immediate pain in the right leg at that time. The patient was initially diagnosed with discogenic lumbar spine pain and treated with conservative therapy. The patient underwent an MRI 5/8/02 that showed some central disc protrusions at L4-L5 and L5-S1. The patient switched his care to a chiropractor 5/29/02 where the treating diagnoses included lumbar disorder with myeoloapthy and lumbar facet syndrome. The patient underwent

and EMG 6/26/02. The patient was then treated with chiropractic care that included a work hardening program. The patient reported a previous back injury approximately one year prior to this injury that was treated with rest and medication.

Requested Services

Chiropractic treatments from 7/8/02 through 9/27/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 42 year-old male who sustained a work related injury to his back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included central disc protrusions at L4-L5 and L5-S1. The ___ chiropractor reviewer further noted that this patient was treated with chiropractic care beginning 5/29/02. The ___ chiropractor reviewer explained that the documentation provided failed to show patient's improvement with care. The ___ chiropractor reviewer indicated that the clinical records did not demonstrate the patient's level of pain, range of motion, neurological testing or any indication on what treatment makes the patient better or worse. The ___ chiropractor reviewer explained that the clinical documentation failed to show the progression of the case, diagnosis, clinical impression and case management. Therefore, the ___ chiropractor consultant concluded that the chiropractic treatments from 7/8/02 through 9/27/02 were not medically necessary to treat this patient's condition.

Sincerely,