MDR Tracking Number: M5-03-2060-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 04-21-03.

The IRO therapeutic exercises, office visits, myofasical release, joint mobilization, unlisted neurological procedure, neuromuscular re-education, muscle testing, range of motion measurements, and therapeutic activities rendered from 12-06-02 through 02-27-03 that were denied based upon "U" and "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for therapeutic activities, therapeutic exercises, neuro-muscular re-education, office visits, myofasical release, joint mobilization, manual traction, range of motion measurements, muscle testing and unlisted neurological procedures. 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.

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

On June 24, 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:

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MAR$ (Maximum Allowable Reimbursement) | Reference | Rationale |
|---|---|---|---|---|---|---|---|
| 12-23-02 | 95851 | $36.00 | 0.00 | G | $36.00 | MFG MGR (I)(E)(4) | Range of Motion testing is not considered global to any other service billed. Recommended Reimbursement $36.00 |
| 02-12-03 | 99213 | $48.00 | 0.00 | No EOB | $48.00 | MFG E/MGR (IV)(C)(2) | Soap notes confirm delivery of service. Recommended Reimbursement $48.00 |
| | 97110 (4 units) | $140.00 | 0.00 | | $35.00 | MFG MGR (I)(A)(9)(b) | See Rational |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 97530 (4 units) | $140.00 | 0.00 | | $35.00 | MFG MGR (I)(11)(b) | Soap notes confirm delivery of service. Recommended Reimbursement $140.00 |
| | 99070 | $15.00 | 0.00 | | DOP | MFG CPT Descriptor | Description of supply not provided unable to confirm delivery of service. Reimbursement is not recommended |
| | 97032 | $22.00 | 0.00 | | $22.00 | MFG MGR (I)(A)(9)(a)(iii) | Soap notes do not confirm delivery of service. Reimbursement is not recommended. |
| 02-19-03 | 97110 | $140.00 | 0.00 | | $35.00 | MFG MGR (I)(A)(9)(b) | See Rational |
| | 97530 (4 units) | $140.00 | 0.00 | | $35.00 | MFG MGR (I)(11)(b) | Soap notes confirm delivery of service Recommended Reimbursement $140.00 |
| | 99213 | $48.00 | 0.00 | | $48.00 | MFG E/MGR (IV)(C)(2) | Soap notes confirm delivery of service. Recommended Reimbursement $48.00 |
| TOTAL | | $729.00 | | | | | The requestor is entitled to reimbursement of **$412.00** |

**Rationale**

Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings 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: Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(9)(b) 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.

**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 12-23-02, 02-12-03, and 02-19-03 in this dispute.

This Decision is hereby issued this 17th day of February 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

**REVISED 2/10/04**

June 11, 2003

IRO Certificate# 5259
MDR Tracking Number: M5-03-2060-01

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
Based on materials provided for review, it appears that this patient reports an injury to her back as a result of a fall after slipping on a wet floor at her place of work on or about ___. No employer's first report (E-1) is provided for review. The patient appears to have presented initially to an unnamed doctor where she received x-rays, medications and therapy for approximately 2x per week for one month. No reports or notes from this provider are provided for review. The patient is then seen on or before 11/29/02 by a chiropractor, ___. No initial report of this evaluation is provided for review. The patient appears to be referred to a ___ (specifically unknown) on 11/29/02. No review of previous x-rays or medical reports appears to be made. Exam reveals normal lumbar ROM and no motor or sensory deficits. SLR tests are negative. The patient is diagnosed with lumbar sprain/strain and lumbar herniated disc. The patient is given medications and asked to continue therapy modalities and treatment with chiropractor. Reports from chiropractor, ___ appear to be first submitted 12/20/03 and are unsigned and clearly computer generated. In the "History of Present Illness" the same paragraph appears to be duplicated 11 times. No review of previous x-rays or medical reports appear to be made. ___ provides a diagnosis of lumbar sprain only. The patient appears to be

referred for MRI and EMG/NCV as well as follow-up with ___. Treatment is assigned at 4x per week with active and passive therapy and exercise. MRI performed 12/05/02 is found essentially normal without disc herniation or any significant disc bulging event. Some early degenerative changes are noted.

Medical follow-ups appear to be made with ___ on 12/09/02, 12/18/02, and 12/30/02. These reports suggest that patient is scheduled for evaluation with an insurance doctor and designated doctor but these reports are not provided for review. ___ now reveals that patient is experiencing decreased ROM, nausea, vomiting, and dizziness as well as a positive SLR on the right at 90 degrees. MRI is reviewed and found to be normal. Diagnosis is well modified to suggest only lumbar strain. Medications appear to be modified and therapy and physical rehab is continued. There appears to be a pre-authorization request for NCV studies made on 1/10/03. There is a Sensory Nerve Conduction Threshold Calculations Sheet dated 12/03/02 with no technician or physician interpretation identified. There is an intake sheet submitted from ___ dated 01/08/03 suggesting a referring physician of a ___. No reports from this doctor are submitted for review. Patient complaints and symptoms appear to all be for tingling, weakness, and pain to the left side only. Chiropractic notes dated 1/08/03 suggest that the patient is experiencing pain in the lower back and leg on the right side only. These notes also indicate a pain index scale of 5, then in the same paragraph note a pain scale number of 4. Again chiropractic notes suggest radiating pain to the areas of the posterior thigh on the right. A second Sensory Nerve Conduction Threshold (CPT) Test Calculation sheet is submitted for 02/11/03, again without professional interpretation or clinical correlation by an identified physician or technician. CPT summary observations indicate slight or no abnormal measures. There appear to be multiple Functional Abilities Evaluation sheets suggesting muscle strength measurements and ROM measurements without specific clinical correlation by doctor or technician. There are multiple “Client Information” sheets submitted with printed treatment dates marked out and then re-written by hand and initialed, apparently by ___. There are also multiple Temperature Gradient Study Sheets submitted with some indiscernible hand written notes. No clinical indications or correlation findings are submitted for review. A number of Physical Evaluation forms are provided beginning 01/09/03 with no specific comments, notes, or clinical correlations noted. No physician or technician appears to be identified and signatures are indiscernible. In addition, no discussion of these findings appears to be made in corresponding doctor’s treatment notes for this day. As 01/09/03, no change in patient’s condition is noted and active and passive modalities are continued for 4x per week for an additional six weeks. Interestingly, anticipated release date is set for 01/31/03. Chiropractic notes from 01/10/03 again makes no mention pf previous test findings and notes no change in condition or pain levels. Care is continued at 3x per week and anticipated release date is changed to 02/07/03 without explanation of complication, exacerbation, or re-injury. Subsequent notes appear identical as far as frequency of care, pain levels, and objective findings through 02/05/03 when new anticipated release date is set at 03/28/03 with no explanation. Passive modalities including myofascial release, joint mobilization, and manual traction appear to be discontinued as of 02/03/03. Patient appears to resume care with therapeutic activities at multiple units; however, no mention is made as to what these specific activities are and what specific functional goals are made. There appears to be multiple mentions of orthopedic referral to a ___ but no reports of this evaluation are provided for review. There appears to be a 02/27/03 order for Lower Extremity EMG studies but no report of these findings is provided for

review either. Chiropractic notes appear to be submitted, essentially unchanged through 02/27/03.

REQUESTED SERVICE (S)
Medical Necessity & Appropriateness of Treatment (Items in Dispute)

DECISION
*Office visits (99213) 12/06/02 – 02/27/03: The 99213 E/M service performed by doctors of chiropractic in the Texas Worker's Compensation System generally includes a physical evaluation component as well as a management component which includes manipulation or mobilization unless otherwise distinguished. On multiple treatment sessions from 12/06/03 through 02/03/03, the chiropractor provided manipulation (adjustments), mobilization (97265), myofascial release (97265), and manual traction (97250) to the same area effecting the same tissues and structures. No appropriate modifier is used to distinguish these similar manual therapies from the primary procedure performed as the management component of service. This appears to be a duplication of same or similar service and is not supported by clinical rationale for conditions described. I can see no appropriate medical necessity for the combination of these services as provided.

*Unlisted Neurological or Neuromuscular Diagnostic Procedures (95999-WP) appears to be billed to represent NCV/EMG studies or Sensory Nerve Conduction Threshold (CPT) Tests. This service appears to have been billed on 02/11/03 and appears to correspond to services documented on 12/20/03 and 1/10/03. Though apparently ordered, no report of EMG service was submitted for review. This service is not appropriately documented. No specific clinical rationale or clinical correlation is provided. No qualified physician's report or interpretation is provided for this date of service. Medical necessity for this service is not supported.

*Muscle Testing (97750-MT) billed on 2/17/03 appears to correspond to Physical Performance Evaluations performed and identified on another date (1/9/03). There are no corresponding notes, comments or clinical correlations made regarding these services made in doctor's notes concerning treatment or diagnostic modifications from this data on either dates (1/9/03 or 2/17/03). These do not appear to meet criteria for functional capacity evaluations. Medical necessity for this service is not supported.

*Range of Motion Measurements (95851) billed on multiple occasions does not appear to directly correspond to documentation submitted. Some DOP relating to ROM services appear to have dates scratched out and then re-written by hand without explanation. In addition, initial examination by Treating ___, from 11/29/02 suggests that lumbar ROMs were normal at that time. In addition, Rom evaluations are generally considered part of the doctor's initial examination and subsequent reexaminations unless specific measurements are necessitated by clinical rationale or other functional indications outlined in doctor's notes. In addition, no specific clinical correlation is provided regarding diagnostic interpretation or treatment modification. Medical necessity for this service is not supported.

*Therapeutic Activities (97530), billed on multiple occasions, requires direct one-to-one patient contact by provider and generally requires a specific outline of activities with specific goals, modifications and response to treatment. Also, provided with this service is Therapeutic Exercise (97110) which also requires DOP, suggesting measurable

change through the application of clinical skills in an attempt to improve specific issues of function. No separate therapists notes are provided outlining who observed or supervised these activities or exactly which activities are provided for which purpose. Though some therapeutic exercise does appear generally appropriate, there is no explanation as to why home exercise and self care instruction is not provided with in a reasonable period within the natural course of care. Medical necessity for level and duration of these services is not supported.

*Therapeutic activities (97530, Therapeutic exercise (97110) and neuromuscular re-education (97112) are not supported by documentation as medically necessary.

RATIONALE/BASIS FOR DECISION

With objective data confirming no specific discopathy or neurology other than degenerative changes observed in imaging, the working diagnosis appears to be uncomplicated mechanical and soft tissue sprain. The natural history for resolution disorders of this nature (lumbar sprain/strain) rarely exceed eight (8) weeks duration without specific complication. No specific complicating factors are outlined in objective testing or doctor's notes (neuropathy, exacerbation, re-injury etc). In addition, no review of initial medical reports x-ray findings, or therapy reports appear to be made. With DOI established at 10/15/02, there appears to be little evidence supporting necessity and rationale for treatment at these levels beyond 12/15/02. Finally, there are many irregularities in chiropractic reporting that questions the necessity of level, frequency, and duration of care provided.

There are also many inconsistencies in medical reporting, chiropractic reporting, and advanced testing that questions the specific issues of medical necessity.

**Other Advisement**

There is a great deal of relevant documentation not provided for review in this file. This missing documentation may have significant bearing on specific issues of medical necessity and appropriateness of treatment. The missing documentation includes or may include:

*Initial examination by ___, prior to 11/29/02.
*Initial medical reports, findings, progress, and recommendations from first provider.
*Findings from RME evaluation or Utilization Review.
*Findings from Designated Doctor and orthopedic consultation.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review.

This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute a per se recommendation for specific claims or administrative functions to be made or enforced.

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.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 17th day of February 2004.