

MDR Tracking Number: M5-03-0348-01

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, 133.307 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 10-02-03.

The IRO reviewed electrodes, office visit outpatient, hot or cold pack therapy, electric stimulation therapy, therapeutic exercises, joint mobilization, group therapeutic procedures rendered from 11-20-02 through 02-28-03 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

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 12-11-03, 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	MARS	Reference	Rationale
10-3-02	99205	\$210.00	\$116.45	N	\$137.00	96 MFG MED GR (VI)(A)	Requestor submitted relevant information to meet documentation criteria. Additional reimbursement recommended in amount of \$20.55
10-3-02	97035	\$182.00	\$112.20	F,C	\$22.00	96 MFG MED	C- Carrier denied for

through 12-3-02 (7 DOS)		(26.00 per unit X 7 DOS)	(\$18.70 X 6 DOS)			GR (I)(9)(a)(iii)	negotiated contract price. Requestor did not challenge carrier's denial rationale. Neither party submitted a copy of the negotiated contract. No reimbursement recommended.
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DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
10-4-02	97265	\$50.00	\$0.00	G	\$43.00	96 MFG MED GR (I)(9)(c)	G- Not global to any other service billed on this date. Requestor submitted relevant information to support delivery of service. Recommend reimbursement in amount of \$43.00
11-13-02 through 1-2-03 (15 DOS)	97010	\$225.00 (\$15.00 1 unit X 15 DOS)	\$140.25 (\$9.35 per DOS X 15 DOS)	F,C	\$11.00	96 MFG MED GR (I)(9)(a)(ii)	C- Carrier denied for negotiated contract price. Requestor did not challenge carrier's denial rationale. Neither party submitted a copy of the negotiated contract. No reimbursement recommended.
12-10-02	97010	\$15.00 (1 unit)	\$9.35	No EOB	\$11.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Recommend additional reimbursement in the amount of \$1.65
1-24-03	97010	\$15.00	\$0.00	F	\$11.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Recommend reimbursement in the amount of \$11.00

11-13-02 through 1-2-03 (15 DOS)	97014	\$270.00 (\$18.00 1 unit X 15 DOS)	\$191.25 (\$12.75 per DOS X 15 DOS)	F,C	\$15.00	96 MFG MED GR (I)(9)(a)(ii)	C- Carrier denied for negotiated contract price. Requestor did not challenge carrier's denial rationale. Neither party submitted a copy of the negotiated contract. No reimbursement recommended
12-10-02	97014	\$18.00 (1 unit)	\$12.75	No EOB	\$15.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Recommend additional reimbursement in the amount of \$2.25
11-13-02 through 12-3-02 & 12-24-02 (10 DOS)	97110	\$800.00 (\$80.00 2 units billed per DOS X 10 DOS)	\$595.00 (\$59.50 paid each DOS X 10 DOS)	F,C	\$35.00	96 MFG MED GR (I)(9)(b)	C- Carrier denied for negotiated contract price. Requestor did not challenge carrier's denial rationale. Neither party submitted a copy of the negotiated contract. No reimbursement recommended.
12-13-02 through 1-24-03 (5 DOS)	97110	\$200.00 (\$40.00 1 unit per DOS X 5 DOS)	\$148.75 (\$29.75 paid each DOS X 5 DOS)	F,C	\$35.00	96 MFG MED GR (I)(9)(b)	C- Carrier denied for negotiated contract price. Requestor did not challenge carrier's denial rationale. Neither party submitted a copy of the negotiated contract. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
12-10-02	97110	\$80.00 (2 units)	\$59.50 (\$29.75 per unit)	No EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.

			paid)				
11-18-02 through 3-10-03 (6 DOS)	99213	\$360.00 (\$60.00 1 unit X 6 DOS)	\$244.80 (\$40.80 paid each DOS X 6 DOS)	F,C	\$48.00	96 MFG MED GR (VI)(B)	C- Carrier denied for negotiated contract price. Requestor did not challenge carrier's denial rationale. Neither party submitted a copy of the negotiated contract. No reimbursement recommended.
11-18-02 through 2-19-03 (3 DOS)	99080	\$60.00 (\$20.00 1 unit X 3 DOS)	\$0.00	F	DOP	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to meet DOP criteria. Reimbursement recommended in amount of \$20.00 X 3 DOS = \$60.00
1-16-03 through 3-10-03 (2 DOS)	99080	\$40.00 (\$20.00 1 unit X 2 DOS)	\$0.00	N,F	DOP	96 MFG General Instructions (III)(A)	Requestor submitted relevant information to meet DOP criteria. Reimbursement recommended in amount of \$20.00 X 2 DOS = \$40.00
12-12-02	97150	\$35.00 (1 unit)	\$22.95	F,C	\$27.00	96 MFG MED GR (I)(10)(a)	C- Carrier denied for negotiated contract price. Requestor did not challenge carrier's denial rationale. Neither party submitted a copy of the negotiated contract. No reimbursement recommended.
1-2-03	E1399	\$30.00	\$0.00	N	DOP	96 MFG DME GR VIII	Requestor did not submit relevant information to meet DOP criteria. No reimbursement

							recommended.
1-24-03	97250	\$44.00 (1 unit)	\$0.00	F	\$43.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of \$43.00
TOTAL		\$2,634.00	\$1,653.25				The requestor is entitled to reimbursement in the amount of \$221.45

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 (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

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 10-03-02 through 02-28-03 in this dispute.

This Findings and Decision and Order is hereby issued this 5th day of April 2004.

Debra L. Hewitt
 Medical Dispute Resolution Officer
 Medical Review Division
 DLH/dlh

December 9, 2003

**NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter**

RE: MDR Tracking #: M5-04-0348-01

___ 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 reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. 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 female who sustained a work related injury on ___. The patient reported that while at work she injured her left elbow while attempting to restrain a patient. Preoperative diagnosis for this patient was left elbow lateral epicondylitis with tennis elbow and extensor tendonitis. The patient was treated with physical therapy that included ultrasound, electrical stimulation and hot/cold packs. On 10/29/02 the patient underwent an arthroscopy of the left elbow, lateral epicondylectomy and reattachment of extensor tendon origin muscles. Postoperatively the patient was treated with therapy that included ultrasound, electrical stimulation and hot/cold packs, therapeutic exercises and joint mobilization.

Requested Services

Electrodes, office visit outpatient, hot/cold pack therapy, electric stimulation therapy, therapeutic exercises, joint mobilization, group therapeutic procedures from 11/20/02 through 2/28/03.

Decision

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

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her left elbow on ____. The ___ chiropractor reviewer also noted that the diagnosis for this patient was left elbow lateral epicondylitis with tennis elbow and extensor tendonitis. The ___ chiropractor reviewer further noted that the patient has been treated with physical therapy that included ultrasound, electrical stimulation and hot/cold packs. The ___ physician reviewer explained that the patient required postoperative rehabilitation. The ___ chiropractor reviewer further explained that the patient responded well to the therapy. Therefore, the ___ chiropractor consultant concluded that the electrodes, office visit outpatient, hot/cold pack therapy, electric stimulation therapy, therapeutic exercises, joint mobilization, group therapeutic procedures from 11/20/02 through 2/28/03 were medically necessary to treat this patient's condition.

Sincerely,