

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO: 453-04-6389.M5**

MDR Tracking Number: M5-04-0891-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 11-24-03.

The IRO reviewed therapeutic exercises, office visits, myofascial release, electrical stimulation, hot/cold packs, ultrasound, and review of MMI/IR report from 12-2-02 through 7-15-03.

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.

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

On 1-29-04, 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\$ (Max. Allowable Reimbursement)	Reference	Rationale
11/25/02	97110 (3 units)	\$105.00	\$70.00	D	\$35.00 ea 15 min	133.307(g)(3) (A-F)	See RATIONALE below. No reimbursement recommended.
11/27/02	97110 (4 units)	\$140.00	\$70.00				
12/16/02	99214	\$76.00	\$0.00	N	\$71.00		Relevant information supports documentation criteria and delivery of service. Recommend reimbursement of \$71.00.
2/10/03	99080-73	\$15.00	\$0.00	F	\$15.00		Requestor submitted relevant information to support delivery of service. Recommend reimbursement of \$15.00.
TOTAL		\$336.00	\$140.00				The requestor is entitled to reimbursement of \$86.00.

**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 (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.

This Decision is hereby issued this 26<sup>th</sup> day of April 2004.

Dee Z. Torres  
 Medical Dispute Resolution Officer  
 Medical Review Division

## 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 Order is applicable for dates of service 12-2-02 through 7-15-03 in this dispute.

This Order is hereby issued this 26<sup>th</sup> day of April 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

February 16, 2004

### REVISED REPORT Corrected Dates of Service.

MDR #: M5-04-0891-01  
IRO Certificate No.: IRO 5055

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ 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 \_\_\_ 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.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

#### Information Provided for Review:

Correspondence  
H&P and office notes  
Physical Therapy notes  
Functional Capacity Evaluation  
Operative Report

#### Clinical History:

This patient injured her right shoulder at work on \_\_\_\_\_. She required arthroscopic surgery in 1999 to her right shoulder, and again in 2002. The surgery in 2002 included an open

distal clavicular resection, as well as arthroscopic debridement, subacromial decompression, synovectomy, and bursectomy.

**Disputed Services:**

Therapeutic exercises, office visits, myofascial release, electrical stimulation, hot/cold packs, ultrasound therapy, and review of MMI/IR report, during the period of 12/02/02 through 07/15/03.

**Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatments and services in disputed as stated above were medically necessary in this case.

**Rationale:**

The orthopaedic surgeon and the designated doctor recommended physical therapy. This patient required 2 surgeries to her right shoulder with the second surgery including an open distal clavicular resection. Other factors that have contributed to the delayed healing include the chronicity of her case, asthma, and hypothyroidism. The disputed services in question were appropriate and helped relieve the symptomatology naturally resulting from the compensable injury as outlined in the Texas Labor Code 408.021. The care provided to this patient is consistent with the Texas Guidelines of Chiropractic Quality Assurance and Practice Parameters, as well as the Mercy Guidelines considering the contributing factors and the chronicity of the case (see chapter 8, page 124-125).

Sincerely,