

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 mechanical traction, aquatic therapy, neuromuscular re-education, electrical stimulation, and therapeutic procedures from 1-20-03 through 2-28-03.

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 2-5-04, 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 | MARS (Max. Allowable Reimbursement) | Reference | Rationale |
|-------------------------------|--|----------------------|--------|-----------------|--|---|--|
| 1-20-03 1-22-03 1-24-03 | 97024 x 3 97014 x 3 | \$25.00 \$17.00 | \$0.00 | F | \$21.00 \$15.00 | Rule 133.307 (g) (3) (A-F) | Requestor failed to submit relevant information to support delivery of service for 1-20-03. No reimbursement recommended. Relevant information supports delivery of service for 1-22-03 and 1-24-3. Recommend reimbursement of 1-24-4. \$21.00 + \$15.00 = \$36.00 x 1-24-5. 2 days = \$72.00. |
| 1-27-03 | 97110 – 6 units 97113 – 5 units | \$105.00 \$260.00 | \$0.00 | A | \$35.00 ea 15 min \$52.00 ea 15 min | Rule 133.307 (g) (3) (A-F) And Rule 134.600 dtd 1-1-03 | Per the rule, physical therapy treatment does not require preauthorization. Therefore, this review will be per the 1996 Medical Fee Guideline. Relevant information supports delivery of service for 97113 only. Recommend reimbursement of \$260.00. 97110: See RATIONALE below |
| 1-29-03 | 97113 – 6 units | \$312.00 | \$0.00 | A | \$52.00 ea 15 min | Rule 133.307 (g) (3) (A-F) And Rule | Per the rule, physical therapy treatment does not require preauthorization. Therefore, this review will be per the 1996 Medical Fee |

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MARS (Max. Allowable Reimbursement) | Reference | Rationale |
|-------------------|-----------------------------------|--------------------------------|--------|-----------------|--|---|---|
| | | | | | | 134.600 dtd 1-1-03 | Guideline. Relevant information supports delivery of service. Recommend reimbursement of \$312.00. |
| 1-31-03 | 99080-73 97113 – 6 units | \$15.00 \$312.00 | \$0.00 | A | \$15.00 \$52.00 ea 15 min | Rule 133.307 (g) (3) (A-F) And Rule 134.600 dtd 1-1-03 | Per the rule, physical therapy treatment and required reports do not require pre-authorization. Therefore, this review will be per the 1996 Medical Fee Guideline. Relevant information supports delivery of service for 97113 only. Recommend reimbursement of \$312.00. |
| 2-10-03 | 99215 | \$100.00 | \$0.00 | No EOB | \$103.00 | Rule 133.307 (g) (3) (A-F) | Neither party submitted an EOB for dates of service 2-10-03 through 2-21-03. Therefore, this review will be per the 1996 Medical Fee Guideline. Relevant information supports delivery of service. Recommend reimbursement of \$100.00. |
| 2-11-03 | 97113 – 7 units 97112 | \$364.00 \$35.00 | \$0.00 | No EOB | \$52.00 ea 15 min \$35.00 ea 15 min \$28.00 ea 15 min \$35.00 ea 15 min | | Relevant information supports delivery of service. Recommend reimbursement of \$364.00 + \$35.00 = \$399.00. |
| 2-12-03 | 97113 – 7 units 97124 | \$364.00 \$30.00 | \$0.00 | No EOB | | | Relevant information supports delivery of service. Recommend reimbursement of \$364.00 + \$28.00 = \$392.00. |
| 2-14-03 | 97113 – 5 units 97112 | \$260.00 \$35.00 | \$0.00 | No EOB | | | Relevant information supports delivery of service. Recommend reimbursement of \$260.00 + \$35.00 = \$295.00. |
| 2-17-03 | 97110 – 7 units 97112 | \$245.00 \$35.00 | \$0.00 | No EOB | | | Relevant information supports delivery of service for 97112. Recommend reimbursement of \$35.00. 97110: See RATIONALE below. |
| 2-19-03 | 97113 – 7 units 97124 | \$364.00 \$30.00 | \$0.00 | No EOB | | | Relevant information supports delivery of service. Recommend reimbursement of \$364.00 + \$28.00 = \$392.00. |
| 2-21-03 | 97113 – 6 units 97112 97124 | \$312.00 \$35.00 \$30.00 | \$0.00 | No EOB | | Rule 133.307 (g) (3) (A-F) | Relevant information supports delivery of service. Recommend reimbursement of \$312.00 + \$35.00 + \$28.00 = \$375.00. |
| 2-28-03 | 97124 | \$30.00 | \$0.00 | F | | | Relevant information supports delivery of service. Recommend reimbursement of \$28.00. |
| 3-3-03 3-31-03 | 99080-73 | \$15.00 x 2 days | \$0.00 | No EOB | \$15.00 | Rule 133.307 (g) (3) (A-F) | Neither party submitted an EOB; therefore, this review will be per the 1996 Medical Fee Guideline. Relevant information supports delivery of service. Recommend reimbursement of \$15.00 x 2 days = \$30.00. |

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MARS (Max. Allowable Reimbursement) | Reference | Rationale |
|---------|-----------------------------------|--------------------------------|--------|-----------------|---|-----------|---|
| 3-5-03 | 97110 – 6 units 97112 97124 | \$210.00 \$35.00 \$30.00 | \$0.00 | No EOB | \$35.00 ea 15 min \$35.00 ea 15 min \$28.00 ea 15 min | | Neither party submitted an EOB for dates of service 3-5-03, 3-6-03, and 4-16-03; therefore, this review will be per the 1996 Medical Fee Guideline. Relevant information supports delivery of service for 97112 and 97124 only. Recommend reimbursement of \$35.00 + \$28.00 = \$63.00. 97110: See RATIONALE below. |
| 3-6-03 | 97110 – 7 units 97112 | \$245.00 \$35.00 | \$0.00 | No EOB | | | Relevant information supports delivery of service for 97112 only. Recommend reimbursement of \$35.00. 97110: See RATIONALE below. |
| 4-16-03 | 99213 | \$48.00 | \$0.00 | No EOB | \$48.00 | | Relevant information supports delivery of service. Recommend reimbursement of \$364.00 + \$35.00 = \$399.00. |
| TOTAL | | \$3,858.00 | \$0.00 | | | | The requestor is entitled to reimbursement of \$3,499.00. |

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 12th day of May 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 1-20-03 through 4-16-03 in this dispute.

This Order is hereby issued this 12th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED

Date: February 11, 2004

RE: MDR Tracking #: M5-04-0892-01

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 a chiropractor physician reviewer who has ADL certification. The chiropractor 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

The claimant is a 37-year-old female employee of ___ since her date of hire on ___. She reported that she was lifting a heavy bundle of pants when she developed lower back pain and lower extremity radicular complaints on ___. The claimant failed to respond to all conservative and medical management then subsequently underwent surgical fusion from L4-S1 on 11/26/2002. The claimant started postoperative rehabilitation to include aquatic therapy in early January 2003.

Requested Service(s)

Mechanical traction, aquatic therapy, neuromuscular re-education, electrical stimulation and therapeutic procedures from 01/20/2003 to 02/28/2003

Decision

I agree with the provider that the disputed services in this claim were reasonable and medically necessary for the purposes postoperative rehabilitation as it relates to this claim.

Rationale/Basis for Decision

The claimant is entitled to 6-8 weeks of supervised postoperative rehabilitation in order to achieve maximal therapeutic benefit to help alleviate the effects of a multilevel L4-S1 lumbar fusion. Electrical stimulation and therapeutic procedures performed were reasonable and medically necessary. Even though the claimant has an extensive past medical history of direct one-on-one care in this claim; postoperative rehabilitation provided that is in question was well normal within the standards of care. Supervised care provided following an invasive procedure of this magnitude should be followed by a properly well trained healthcare provider whether or not the claimant has been previously instructed in a home exercise program.