

MDR Tracking Number: M5-04-0938-01

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 12-01-03.

The IRO reviewed office visits, special report, therapeutic procedures, ultrasound therapy, myofascial release, physical medicine treatment and joint mobilization rendered from 01-27-03 through 06-27-03 that were denied based upon “V” and “U”.

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
1-27-03	99213	\$60.00	\$0.00	V	\$48.00	IRO Decision	No reimbursement recommended.
1-27-03	99080-73	\$15.00	\$0.00	V	\$15.00	IRO Decision	No reimbursement recommended.
3-18-03 and 6-27-03 (2 DOS)	99212-25	\$45.00 (1 unit X 2 DOS)	\$0.00	U	\$32.00	IRO Decision	No reimbursement recommended.
5-23-03	97018	\$24.00 (1 unit)	\$0.00	V	\$16.00	IRO Decision	Reimbursement recommended in amount of \$16.00
5-23-03	97265	\$50.00 (1 unit)	\$0.00	V	\$43.00	IRO Decision	Reimbursement recommended in amount of \$43.00
5-23-03	97250	\$45.00 (1 unit)	\$0.00	V	\$43.00	IRO Decision	Reimbursement recommended in amount of \$43.00
6-16-03 through 6-24-03 (4 DOS)	97035	\$180.00 (1 unit @ \$45.00 X 4 DOS)	\$0.00	V	\$22.00	IRO Decision	No reimbursement recommended.
6-16-03 through 6-27-03 (4 DOS)	97018	\$96.00 (1 unit @ \$24.00 X 4 DOS)	\$0.00	V	\$16.00	IRO Decision	No reimbursement recommended.
6-16-03	97250	\$180.00	\$0.00	V	\$43.00	IRO	No reimbursement recommended.

through 6-26-03 (4 DOS)		(1 unit @ \$45.00 X 4 DOS)				Decision	
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DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
6-16-03 through 6-27-03 (6 DOS)	97110	\$900.00 (1 unit @ \$45.00 X 20 units)	\$0.00	V	\$35.00	IRO Decision	No reimbursement recommended.
6-19-03 through 6-26-03 (3 DOS)	97265	\$150.00 (1 unit @ \$50.00 X 3 DOS)	\$0.00	V	\$43.00	IRO Decision	No reimbursement recommended.
TOTAL		\$1,790.00					The requestor is entitled to reimbursement of \$102.00

The IRO concluded that office visits (99213/99215-25), special report (99080-73), therapeutic procedures (97110), ultrasound therapy (97035), myofascial release (97250), physical medicine treatment (97018) and joint mobilization (97265) for dates of service 01-27-03, 03-18-03 and 06-16-03 through 06-27-03 were not medically necessary. The IRO concluded that physical medicine treatment (97018), joint mobilization (97265) and myofascial release (97250) on date of service 05-23-03 were medically necessary.

On this basis, the total amount recommended for reimbursement (\$102.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. 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.

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

On 03-17-04, 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 (Maximum Allowable Reimbursement)	Reference	Rationale
3-18-03	97018	\$24.00 (1 unit)	\$0.00	F	\$16.00	Rule 133.307 (g)(3) (A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$16.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
3-18-03	97265	\$50.00 (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 the amount of \$43.00
3-18-03	97250	\$45.00 (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 the amount of \$43.00
3-18-03	E1399-EMS	\$235.00 (1 unit)	\$0.00	F	DOP	96 MFG DME GR VIII	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$235.00
3-18-03	97110	\$135.00 (3 units)	\$0.00	F	\$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
TOTAL		\$489.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$337.00

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.

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 01-27-03 through 06-27-03 in this dispute.

This Findings and Decision and Order are hereby issued this 30th day of April 2004.

Debra L. Hewitt
Medical Dispute Resolution
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION amended 4/23/04
March 12, 2004

Re: IRO Case # M5-04-0938-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to

___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a female who reported a repetitive stress injury to both upper extremities in ___. The patient was diagnosed with bilateral carpal tunnel syndrome and deQuervain's tenosynovitis. She underwent numerous treatments, including physical therapy and modalities. Ultimately, she underwent surgical treatment of her bilateral carpal tunnel syndrome and received first extensor tendon sheath steroid injections at the time of her carpal tunnel surgeries. The left carpal tunnel surgery was on 2/12/03, and the right on 4/2/03. The patient received 37 postoperative physical therapy visits after the surgical procedures, and these were approved by the carrier. Multiple subsequent physical therapy visits have been denied.

Requested Service(s)

OVS, special report, therapeutic procs, ultrasound therapy, myofascial release, phys med tx, jnt mobil 1/27/03-6/27/03

Decision

I agree with the carrier's decision to deny the requested services, except for the procedures performed on 5/23/03.

I disagree with the decision to deny the procedures on 5/23/03.

Rationale

The office visit on 1/27/03 was not necessary, as the patient saw her treating surgeon on the same day, who went over the surgery in great detail. The second visit on the same day did not add to the patient's understanding of what care would be medically necessary. In addition, no documentation was provided for this review that would support a review of outside medical records over and above that necessary to discuss the patient's care plan.

No documentation was provided to support the charges on 3/18/03. The procedures performed on 5/23/03 are reasonably within the postoperative period and were appropriate.

The disputed care beyond 5/23/03 was excessive and not medically necessary. The records provided for this review do not demonstrate the necessity of the services. A home exercise program would have been appropriate at that point.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.
