

MDR Tracking Number: M5-04-0960-01

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 12-02-03.

The IRO reviewed therapeutic activities, supplies/materials, office visits, joint mobilization, myofascial release, manual traction therapy, therapeutic exercises, functional capacity examination, MRI and work hardening rendered from 02-06-03 through 07-14-03 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

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 04-27-04, 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	Reference	Rationale
1-9-03 through 2-12-03 (12 DOS)	99213	\$576.00 (1 unit @ \$48.00 X 12 DOS)	\$264.00 (\$24.00 paid X 11 DOS)	H	\$48.00	Rule 133.307 (g)(3)(A-F)	H – Reimbursement based upon half of fee amount pending audit or review decision. Requestor did not submit relevant information to support delivery of service. No additional reimbursement recommended.
1-9-03 through 2-20-03 (18 DOS)	97265	\$774.00 (1 unit @	\$365.50 (\$21.50 paid X 17 DOS)	H	\$43.00	Rule 133.307 (g)(3)(A-F)	H – Reimbursement based upon half of fee amount pending audit or review decision. Requestor did not submit

		\$43.00 X 18 DOS)					relevant information to support delivery of service. No additional reimbursement recommended.
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DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
1-9-03 through 2-20-03 (18 DOS)	97250	\$774.00 (1 unit @ \$43.00 X 18 DOS)	\$365.50 (\$21.50 paid X 17 DOS)	H	\$43.00	Rule 133.307 (g)(3)(A-F)	H – Reimbursement based upon half of fee amount pending audit or review decision. Requestor did not submit relevant information to support delivery of service. No additional reimbursement recommended.
1-9-03 through 2-20-03 (18 DOS)	97122	\$630.00 (1 unit @ \$35.00 X 18 DOS)	\$297.50 (\$17.50 paid X 17 DOS)	H	\$35.00	Rule 133.307 (g)(3)(A-F)	H – Reimbursement based upon half of fee amount pending audit or review decision. Requestor did not submit relevant information to support delivery of service. No additional reimbursement recommended.
1-9-03 through 2-20-03 (13 DOS)	97110	\$1,820.00 (4 units @ \$140.00 X 13 DOS)	\$910.00 (paid \$70.00 X 13 DOS)	H	\$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No additional reimbursement recommended.
1-28-03 through 2-19-03 (6 DOS)	97110	\$840.00 (4 units @ \$140.00 X 6 DOS)	\$0.00	F	\$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No additional reimbursement recommended.
2-3-03	97110	\$140.00 (4 units)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No additional reimbursement recommended.
1-29-03	99213	\$48.00 (1 unit)	\$0.00	N	\$48.00	96 MFG E/M GR (VI)(B)	Requestor did not submit relevant

							information to meet documentation criteria. No reimbursement recommended.
1-29-03	97265	\$43.00 (1 unit)	\$0.00	N	\$43.00	96 MFG MEDICINE GR (I)(c)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.
1-29-03	97250	\$43.00 (1 unit)	\$0.00	N	\$43.00	96 MFG MEDICINE GR (I)(c)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.
1-29-03	97122	\$35.00 (1 unit)	\$0.00	N	\$35.00	96 MFG MEDICINE GR (I)(b)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.
2-19-03	99213	\$48.00 (1 unit)	\$0.00	F	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
2-3-03	99213	\$48.00 (1 unit)	\$0.00	NO EOB	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
2-3-03	97265	\$43.00 (1 unit)	\$0.00	NO EOB	\$43.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
2-3-03	97250	\$43.00 (1 unit)	\$0.00	NO EOB	\$43.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.

2-3-03	97122	\$35.00 (1 unit)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
5-14-03 through 6-30-03 (9 DOS)	97545- WH- AP	\$1,152.00 (2 units @ \$128.00 X 9 DOS)	\$0.00	NO EOB	\$64.00 (CARF provider)	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
5-14-03 through 6-30-03	97546- WH- AP	\$3,456.00 (6 units @ \$384.00 X 9 DOS)	\$0.00	NO EOB	\$64.00 (CARF provider)	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
5-15-03 through 7-3-03 (5 DOS)	97545- WH- AP	\$640.00 (2 units @ \$128.00 X 5 DOS)	\$307.20 (\$102.40 paid X 3 DOS)	F	\$64.00 (CARF provider)	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No additional reimbursement recommended.
5-15-03 through 7-3-03 5 DOS)	97546- WH- AP	\$1,920.00 (6 units @ \$384.00 X 5 DOS)	\$921.60 (\$307.20 paid X 3 DOS)	F	\$64.00 (CARF provider)	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No additional reimbursement recommended.
6-2-03 6-17-03 6-27-03 (3 DOS)	97545- WH- AP	\$384.00 (2 units @ \$128.00 X 3 DOS)	\$0.00	N	\$64.00 (CARF provider)	96 MFG MEDICINE GR (I)(E)(3-5)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.
6-2-03 6-17-03 6-27-03 (3 DOS)	97546- WH- AP	\$1,152.00 (6 units @ \$384.00 X 3 DOS)	\$0.00	N	\$64.00 (CARF Provider)	96 MFG MEDICINE GR (I)(E)(3-5)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
6-2-03 6-17-03 6-27-03 (3 DOS)	97546- WH- AP	\$1,152.00 (6 units @ \$384.00 X 3 DOS)	\$0.00	N	\$64.00 (CARF provider)	96 MFG MEDICINE GR (I)(E)(3-5)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.
7-7-03	97545- WH- AP	\$128.00 (2 units)	\$0.00	A	\$64.00 (CARF provider)	96 MFG MEDICINE GR (I)(E)(3-5)	A- Denied for preauthorization. No preauthorization needed CARF provider. Reimbursement recommended in the amount of \$128.00
7-7-03	97546- WH- AP	\$384.00 (6 units)	\$0.00	A	\$64.00 (CARF provider)	96 MFG MEDICINE GR (I)(E)(3-5)	A- Denied for preauthorization. No preauthorization needed CARF provider. Reimbursement recommended in the amount of \$384.00
TOTAL		\$16,308.00	\$3,431.00				The requestor is entitled to reimbursement in the amount of \$512.00

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 date of service 07-07-03 in this dispute.

This Findings and Decision and Order are hereby issued this 20th day of May 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

February 6, 2004

Amended February 9, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-04-0960-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ was treated for injuries sustained on ___ when he hurt his thoracic and rib area while using a shooter shovel. He was treated for approximately six months by ___ at ___. During this time, the patient was afforded passive and active therapy followed by work hardening.

DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic activities, supplies/materials, office visits, joint mobilization, myofascial release, manual traction therapy, therapeutic exercises, functional capacity examination, MRI and work hardening provided from 2/6/03 through 7/14/03.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

A mountain of documentation was provided by ___ office that showed very little evidence of improvement per the subjective and objective findings. The FCE obtained on 3/31/03 showed the patient only able to perform sedentary duty ___ post injury. A thoracic MRI on 4/23/03 was normal. On 10/14/03 the patient requested a change of treating doctors, stating that he had not yet seen any improvement.

The reviewer finds that this patient should have been referred within a few weeks, as no improvement, subjective or objective, was noted. As such, the care in question is found to be medically unnecessary.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,