

**THIS MDR TRACKING NO. WAS WITHDRAWN.
THE AMENDED MDR TRACKING NO. IS : M5-04-3514-01**

MDR Tracking Number: M5-04-1005-01

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 12-08-03. Per Rule 133.308(e)(1) dates of service 12-02-02 through 12-11-02 were not timely filed.

The IRO reviewed neuromuscular shock unit, hot/cold pack therapy, electrical stimulation, ultrasound therapy, neuromuscular re-education, therapeutic activities, therapeutic exercises, electrical stimulation-unattended, unlisted modality, unlisted physician medical service, functional capacity evaluation, unlisted special service, office visit, office visit with manipulation, prolonged evaluation and management, medical conference by physician and analysis of data in computer rendered from 12-12-02 through 09-25-03 that was denied based upon "V" and "U".

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 01-30-04, 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\$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-17-02 through 12-31-02 (4 DOS)	99213-MP	\$300.00 (1 unit @ \$75.00 X 4 DOS)	\$0.00	O	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent submitted original explanation of benefits. Reviewer cannot determine original reason for denial. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-17-02 through 12-19-02 (2 DOS)	99199	\$50.00 (1 unit @ \$25.00 X 2 DOS)	\$0.00	G	DOP	Rule 133.307 (g)(3)(A-F)	G – Not global to any other service billed on date of service. Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$25.00 X 2 DOS = \$ 50.00
12-18-02	97010-59	\$30.00 (2 units)	\$11.00	F, G	\$11.00	Rule 133.307 (g)(3)(A-F)	G – Not global to any other service billed on date of service. Requestor submitted relevant information to support delivery of service. Additional reimbursement recommended in the amount of \$22.00 - \$11.00 = \$11.00
12-18-02	97112-59	\$70.00 (2 units)	\$0.00	F	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$35.00 X 2 = \$70.00
12-19-02	97530	\$35.00 (1 unit)	\$0.00	F	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$35.00
12-19-02	99361	\$53.00 (1 unit)	\$0.00	G	\$53.00	96 MFG E/M GR (XVIII)(B)	G – Not global to any other service billed on date of service. Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$53.00
12-30-02 through 2-5-03 (3 DOS 4 units billed)	99213-MP	\$275.00 (1 unit @ \$75.00 X 3 DOS, 1 unit @ \$50.00 X 1 DOS)	\$0.00	NO EOB	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$48.00 X 4 units = \$192.00

DOS	CPT Code	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-30-02	97010-59	\$30.00 (2 units)	\$11.00	NO EOB	\$11.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Additional reimbursement recommended in the amount of \$22.00 - \$11.00 = \$11.00
12-30-02 through 8-22-03 (11 DOS)	99199	\$275.00 (1 unit @ \$25.00 X 11 DOS)	\$0.00	NO EOB	DOP	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support DOP criteria. Reimbursement recommended in the amount of \$25.00 X 11 DOS = \$275.00
12-31-02	97010-59	\$30.00 (2 units)	\$11.00	F	\$11.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Additional reimbursement recommended in the amount of \$22.00 - \$11.00 = \$11.00
1-27-03 through 9-5-03 (3 DOS)	97010-59	\$75.00 (1 unit @ \$15.00 X 1 DOS and 2 units @ \$30.00 X 2 DOS)	\$0.00	NO EOB	\$11.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$11.00 X 5 units = \$55.00
1-27-03 through 3-11-03 (3 DOS)	97032-59	\$75.00 (1 unit @ \$25.00 X 3 DOS)	\$0.00	NO EOB	\$22.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$22.00 X 3 DOS = \$66.00
1-27-03 through 2-5-03 (2 DOS)	97035-59	\$50.00 (1 unit @ \$25.00 X 2 DOS)	\$0.00	NO EOB	\$22.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$22.00 X 2 DOS = \$44.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
1-27-03 through 2-5-03 (2 DOS)	97112-59	\$140.00 (2 units @ \$70.00 X 2 DOS)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$35.00 X 2 units X 2 DOS = \$140.00
2-5-03	97530-59	\$35.00 (1 unit)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$35.00
2-21-03	97110-59	\$35.00 (1 unit)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
4-22-03 through 6-9-03 (2 DOS)	99358	\$150.00 (1 unit @ \$60.00 for 1 DOS and 1 unit @ \$90.00 for 1 DOS)	\$0.00	NO EOB	\$84.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$60.00
5-1-03	99090	\$110.00 (1 unit)	\$0.00	G	\$108.00	Rule 133.307 (g)(3)(A-F)	G- Not global to any other service billed on date of service. Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$108.00
7-1-03	99213	\$50.00 (1 unit)	\$0.00	NO EOB	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$48.00
7-28-03 through 8-22-03 (8 DOS)	97799-CP	\$10,560 (8 units @ \$1,320 X 8 DOS)	\$0.00	NO EOB	DOP	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support DOP criteria. Reimbursement recommended in the amount of \$1,320.00 X 8 DOS = \$10,560.00
9-5-03	97039-59	\$30.00 (1 unit)	\$0.00	NO EOB	\$15.00 Medicare Fee Schedule	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	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
9-5-03	99213	\$68.00 (1 unit)	\$0.00	NO EOB	\$44.00 Medicare Fee Schedule	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
9-15-03	99361	\$53.00 (1 unit)	\$0.00	NO EOB	\$53.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
9-23-03	99455-WP	\$300.00 (1 unit)	\$0.00	N	DOP	96 MFG E/M GR (XXII)(D) (1)(a)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$300.00
9-23-03	99455-WP	\$300.00 (2 units)	\$0.00	NO EOB	DOP	96 MFG E/M GR (XXII)(D) (1)(a)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$300.00
9-23-03	99080-69	\$20.00	\$0.00	G,N	\$15.00	Rule 133.106(f)	G – Not global to any other service billed on date of service. Requestor did not submit relevant information to meet documentation criteria.
TOTAL		\$13,199	\$33.00				The requestor is entitled to reimbursement in the amount of \$12,424.00

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 7th day of May 2004.

Debra L. Hewitt
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 Decision is applicable for dates of service 12-17-02 through 09-23-03 in this dispute.

This Order is hereby issued this 7th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dlh

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-04-1005-01
IRO Certificate# 5259

January 28, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

Patient injured at work on ___ while attempting to carry heavy posts, fell backwards injuring his right shoulder, neck and lower back. Patient received extensive physical medicine treatments and underwent shoulder surgery.

REQUESTED SERVICE (S)

E0745-NU Neuromuscular shock unit, 97010-59 Hot/Cold Pack Therapy, 97032-59 Electrical Stimulation, 07035-59 Ultrasound, 97112-59 Neuromuscular Re-education, 97530-59 Therapeutic Activities, 97110-59 Therapeutic Exercises, 97014 Electrical Stimulation Unattended, 97039-59 unlisted modality, 97799-CP Unlisted Physician Medical Service, 97750-FC Functional Capacity Evaluation, 99199 Unlisted Special Service, 99213-OV, 99213-MP-OV with manipulation, prolonged evaluation, 99361 Medical Conference by Physician, 99358-52, 99090 Analysis of data in computer from dates of service 12/12/02 to 9/25/03.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

___ records fail to substantiate in any way whatsoever that the aforementioned services fulfilled the requirements of Texas Labor Code 408.021 that states:

- “a) An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that:
- (1) cures or relieves the effects naturally resulting from the compensable injury;
 - (2) promotes recovery; or
 - (3) enhances the ability of the employee to return to or retain employment.”

The records indicate the exact opposite since the patient obtained no relief from the treatments, promotion of recovery was not accomplished and there was no enhancement of the employee’s ability to return to work. For documentation, you have to look no further than the provider’s records. On most every visit during the time period in question, the pain rating remained constant at either 6 or 7 (out of 10) and the provider’s records indicate (in the “Assessment” section) that the patient’s condition had not improved. Therefore, without question, the referenced care was not indicated and was not medically necessary.