

MDR Tracking Number: M5-04-1019-01

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 12-08-03.

The IRO reviewed therapeutic procedures, therapeutic activities and myofascial release rendered from 02-27-03 through 08-09-03 that were denied based upon “V”.

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	MARS	Reference	Rationale
02-27-03 03-07-03 03-11-03 03-14-03 (4 DOS)	97110	\$350.00 (1 unit @ \$35.00 X 2 DOS, 4 units @ \$140.00 X 2 DOS)	\$0.00	V	\$35.00	IRO DECISION	The IRO determined services were medically necessary. Reimbursement recommended in the amount of \$35.00 X 10 units = \$350.00
02-27-03 03-28-03 03-31-03 04-04-03 04-09-03 04-13-03 04-17-03 (7 DOS)	97110	\$2,450.00 (10 units @ \$350.00 X 7 DOS)	\$0.00	V	\$35.00	IRO DECISION	The IRO determined services were medically necessary. Reimbursement recommended in the amount of \$35.00 X 70 units = \$2,450.00
03-07-03 03-11-03 03-21-03 04-02-03 04-03-03 04-15-03 04-16-03 04-18-03 04-19-03 04-21-03 (10 DOS)	97110	\$1,750.00 (5 units @ \$175.00 X 10 DOS)	\$0.00	V	\$35.00	IRO DECISION	The IRO determined services were medically necessary. Reimbursement recommended in the amount of \$35.00 X 50 units = \$1,750.00
02-27-03 THROUGH 04-21-03 (17 DOS)	97530	\$1,680.00 (2 units @ \$70.00 X 10 DOS and 4 units @ \$140.00 X 7 DOS))	\$0.00	V	\$35.00	IRO DECISION	The IRO determined services were medically necessary. Reimbursement recommended in the amount of \$35.00 X 48 units = \$1,680.00
03-11-03 THROUGH 04-21-03 (8 DOS)	97250	\$360.00 (1 unit @ \$45.00 X 8 DOS)	\$0.00	V	\$43.00	IRO DECISION	The IRO determined services were medically necessary. Reimbursement recommended in the amount of \$43.00 X 8 dos = \$360.00
04-22-03 THROUGH	97110	\$7,350.00 (5 units @	\$0.00	V	\$35.00	IRO DECISION	The IRO determined services were not medically necessary. No reimbursement

07-18-03 (42 DOS)		\$175.00 X 42 DOS)					recommended.
04-24-03 05-12-03 05-19-03 05-22-03 06-06-03 06-17-03 07-24-03 07-31-03 (8 DOS)	97110	\$2,800.00 (10 units @ \$350.00 X 8 DOS)	\$0.00	V	\$35.00	IRO DECISION	The IRO determined services were not medically necessary. No reimbursement recommended.
04-22-03 THROUGH 07-31-03 (41 DOS)	97530	\$2,870.00 (2 units @ \$70.00 X 41 DOS)	\$0.00	V	\$35.00	IRO DECISION	The IRO determined services were not medically necessary. No reimbursement recommended
05-12-03 05-19-03 06-06-03 06-16-03 06-17-03 07-24-03 (6 DOS)	97530	\$840.00 (4 units @ \$140.00 X 6 DOS)	\$0.00	V	\$35.00	IRO DECISION	The IRO determined services were not medically necessary. No reimbursement recommended
04-23-03 THROUGH 07-18-03 (28 DOS)	97250	\$1,260.00 (1 unit @ \$45.00 X 28 dOS)	\$0.00	V	\$43.00	IRO DECISION	The IRO determined services were not medically necessary. No reimbursement recommended
06-06-03	97250	\$90.00 (2 units)	\$0.00	V	\$43.00	IRO DECISION	The IRO determined services were not medically necessary. No reimbursement recommended
TOTAL		\$21,800.00					The requestor is entitled to reimbursement of \$ 6,590.00

The IRO concluded that therapeutic procedures, therapeutic activities and myofascial release for the initial 18 sessions of chiropractic care **were medically necessary**. The IRO concluded that sessions following the initial 18 **were not medically necessary**.

On this basis, the total amount recommended for reimbursement (\$6,590.00) 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 03-09-04, 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
02-13-03	97110	\$175.00 (1 unit @ \$35.00 X 5 units)	\$0.00	D	\$35.00	Rule 133.307 (g)(3)(A-f)	See rationale below. No reimbursement is recommended.
02-13-03	97530	\$70.00 (1 unit @ \$35.00 X 2 units)	\$0.00	D	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
02-13-03 through 07-31-03 (38 DOS)	97140	\$1,171.00 (1 unit @ \$45.00 X 38 DOS)	\$0.00	N	\$0.00	96 MFG General Instructions (I)(D)	Requestor billed with an invalid code per the 1996 Medical Fee Guideline. No reimbursement recommended.
02-20-03	97140	\$45.00 (1 unit)	\$0.00	F	\$0.00	96 MFG General Instructions (I)(D)	Requestor billed with an invalid code per the 1996 Medical Fee Guideline. No reimbursement recommended.
02-28-03 through 03-24-03 (9 DOS)	97250	\$405.00 (1 unit @ \$45.00 X 9 DOS)	\$0.00	F	\$0.00	96 MFG General Instructions (I)(D)	Requestor billed with an invalid code per the 1996 Medical Fee Guideline. No reimbursement recommended.
03-03-03 through 03-24-03 (6 DOS)	97110	\$1,225.00 (1 unit @ \$35.00 x 35 units)	\$525.00	F	\$35.00	96 MFG MEDICINE GR (I)(9)(b)	See rationale below. No reimbursement recommended.
03-03-03 through 05-12-03 (13 DOS)	99213	\$650.00 (1 unit @ \$50.00 X 13 DOS)	\$0.00	F	\$48.00	96 MFG E/M GR(VI)(B)	The requestor raised no other denial reason. Reimbursement recommended in the amount of \$650.00 (\$50.00 X 13 DOS)
03-12-03	97530	\$70.00 (1 unit @ \$35.00 X 2 units)	\$0.00	F	\$35.00	96 MFG MEDICINE GR (9)(c)	The requestor raised no other denial reason. Reimbursement recommended in the amount of \$70.00 (\$35.00 X 2 units)

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
03-31-03	97140	\$45.00	\$0.00	NO EOB	\$0.00	96 MFG General Instructions (I)(D)	Requestor billed with an invalid code per the 1996 Medical Fee Guideline. No reimbursement recommended.
07-03-03	97140	\$45.00	\$0.00	Invalid CPT code	\$0.00	96 MFG General Instructions (I)(D)	Requestor billed with an invalid code per the 1996 Medical Fee Guideline. No reimbursement recommended.
TOTAL		\$3,901.00					The requestor is entitled to reimbursement in the amount of \$720.00

**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 Findings and Decision is hereby issued this 30<sup>th</sup> day of August 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 02-27-03 through 04-21-03 in this dispute.

This Order is hereby issued this 30th day of August 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

March 4, 2004

**AMENDED LETTER 07/13/04**  
**AMENDED LETTER 08/04/04**

Rosalinda Lopez  
Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE:                    MDR Tracking #:                    M5-04-1019-01  
                          IRO Certificate #:                    IRO4326

The \_\_\_ 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 rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. \_\_\_'s health care professional 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

This patient sustained an injury on \_\_\_ from repetitive motions performed at work. She reported right wrist, hand, forearm, and shoulder pain with numbness and tingling. Electrodiagnostic testing performed 11/03/03 revealed mild carpal tunnel syndrome in the right wrist and right shoulder tendonitis.

### Requested Service(s)

Therapeutic procedures, therapeutic activities, and myofascial release from 02/27/03 through 08/09/03

### Decision

It is determined that the therapeutic procedures, therapeutic activities, and myofascial release for the initial 18 sessions of chiropractic care were medically necessary to treat this patient's condition. However, the therapeutic procedures, therapeutic activities, and myofascial release after the initial 18 sessions were not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

This patient's injury did warrant a trial of conservative chiropractic therapeutics. However, the trial needs to be controlled with quantitative/qualitative data collected in a periodic fashion. The chiropractor in this case did not provide sufficient medical records to warrant the application of further therapeutic trials beyond the initial trial of 18 sessions. The records reviewed did not support the need for treatment after this, moreover the over 50 sessions completed. Pain generators over the patient's upper quarter continued to be insufficiently identified in the reviewed materials. Therefore, it is determined that the therapeutic procedures, therapeutic activities, and myofascial release for the initial 18 sessions of chiropractic care were medically necessary. However, the therapeutic procedures, therapeutic activities, and myofascial release after the initial 18 sessions were not medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- Bellamy R. Compensation neurosis: financial reward for illness as nocebo. Clin Orthop. 1997 Mar;(336):94-106.
- Bonde JP, et al. *Prognosis of shoulder tendonitis in repetitive work: a follow up study in a cohort of Danish industrial and service workers.* Occup Environ Med. 2003 Sep;60(9):E8.
- Madeleine P, et al. *The effects of neck-shoulder pan development on sensory-motor interactions among female workers in the poultry and fish industries. A prospective study.* Int Arch Occup Environ Health. 2003 Feb;76(1):39-49.
- *Overview of implementation of outcome assessment case management in the clinical practice.* Washington State Chiropractic Association; 2001. 54p.

Sincerely,