

MDR Tracking Number: M5-04-1063-01

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 12-11-03.

The IRO reviewed hot or cold pack therapy, therapeutic exercises, electrical stimulation-unattended, ultrasound therapy, myofascial release, therapeutic procedures, office visits with manipulation and required reports rendered from 01-17-03 through 04-09-03 that was denied based upon "V".

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.

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 03-04-04, 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
3-5-03 through 3-13-03 (2 DOS)	99213-MP	\$120.00 (1 unit @ \$60.00 X 2 DOS)	\$0.00	F	\$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 2 DO S= \$96.00
1-30-03	97110	\$160.00 (4 units)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
1-20-03	97110	\$80.00 (2 units)	\$0.00	F	\$35.00	Rule 133.307 (g)(3) A-F)	See rationale below. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
1-20-03	97014	\$18.00 (1 unit)	\$0.00	D	\$15.00	Rule 133.307 (g)(3) A-F)	Denied as a duplicate. Requestor nor respondent provided original explanation of benefits. Reviewer cannot determine reason for denial. No reimbursement recommended.
1-20-03	97010	\$15.00 (1 unit)	\$0.00	D	\$11.00	Rule 133.307 (g)(3) A-F)	Denied as a duplicate. Requestor nor respondent provided original explanation of benefits. Reviewer cannot determine reason for denial. No reimbursement recommended.
TOTAL		\$393.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$96.00

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 4th 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 01-17-03 through 04-09-03 in this dispute.

This Order is hereby issued this 4th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

March 3, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1063-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 44 year-old male who sustained a work related injury on ___. The patient reported that while at work he slipped and fell injuring his low back, right knee and right leg. X-Rays of the SI joint dated 12/12/02 were reported normal, and the impression on lumbar x-rays dated 12/12/02 was status post laminectomies, complete, of L5 and S1, status post fusion of L5 to S1, posterior, diminished height of the intervertebral disc between L5 and S1, diminished height of the intervertebral disc between L2 and L3, and minimal dextroscoliosis of the lumbar spine. On 1/3/03 the patient underwent a MRI of the gluteal regions that indicated degenerative disc disease at the level of L5-S1. The patient underwent a MRI of the lumbar spine on 2/3/03 that showed previous surgical changes at the L5-S1 level with some epidural scarring, slight annular bulging at the L2-L4 level, and a desiccation of the disc at the L1-L2 and L2-L3 levels. Treatment for this patient has included hot/cold therapy, electrical stimulation, therapeutic exercises, myofascial released, therapeutic procedures, and manipulations. The patient has also undergone trigger point injections of the gluteus medius and bilateral SI joint injections.

Requested Services

Hot/cold pack therapy, electrical stimulation-unattended, ultrasound, therapeutic exercises, myofascial release, therapeutic procedures, MP-OV-manipulation, and req reports from 1/17/03 through 4/9/03

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this patient concerns a 44 year-old male who sustained a work related injury to his low back, right knee, and right leg. The ___ chiropractor reviewer indicated that the patient had a pre existing lumbar fusion that alters the mechanics of the rest of the patient's spine. The ___ chiropractor reviewer explained that in addition to this pre existing lumbar fusion, the patient sustained a severe torsion injury to the lumbar/sacral spine and SI joints. The ___ chiropractor reviewer also explained that because of this patient's diagnoses, the recovery process would be longer. The ___ chiropractor reviewer indicated that the patient's care required a multidisciplinary approach and progress was well documented. The ___ chiropractor reviewer explained that the patient made slow but steady progress with the treatment rendered. The ___ chiropractor reviewer also explained that the documentation provided indicated that the patient was not a candidate for surgery. Therefore, the ___ chiropractor consultant concluded that the hot/cold pack therapy, electrical stimulation-unattended, ultrasound, therapeutic exercises, myofascial release, therapeutic procedures, MP-OV-manipulation, and req reports from 1/17/03 through 4/9/03 were medically necessary to treat this patient's condition.

Sincerely,