

MDR Tracking Number: M5-04-1121-01

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 12-18-03.

The IRO reviewed office visits-established patient, therapeutic activities, therapeutic exercises, ultrasound therapy, gait training, electrical stimulation-unattended, special reports, hot/cold pack therapy and electrical stimulation rendered from 02-24-03 through 09-26-03 that were denied based upon "V".

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

The IRO determined that therapeutic activities, therapeutic exercises, gait training and special reports from 02-24-03 through 06-01-03 **were** medically necessary. The IRO determined that office visits-established patient, ultrasound therapy, electrical stimulation, hot/cold pack therapy and electrical stimulation-unattended from 02-24-03 through 09-26-03 **were not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 03-18-04, 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.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's for CPT code 97110 for dates of service 09-02-03, 09-03-03 and 09-05-03. 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.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's for CPT code 97035 for dates of service 09-02-03, 09-03-03, 09-05-03 and 09-19-03. Review of the reconsideration HCFA's reflected proof of submission for dates of service 09-02-03, 09-03-03 and 09-05-03. No proof of submission for date of service 09-19-03 was submitted. Reimbursement is recommended according to the Medical Fee Guideline effective 08-01-03 in the amount of \$ 46.68 (\$15.56 X 3 DOS).

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's for CPT code 97032 for dates of service 09-02-03, 09-03-03 and 09-05-03. Review of the reconsideration HCFA's reflected proof of submission for dates of service 09-02-03, 09-03-03 and 09-05-03. Reimbursement is recommended according to the Medical Fee Guideline effective 08-01-03 in the amount of \$62.55 (\$20.85 X 3 DOS).

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's for CPT code 97010 for dates of service 09-02-03, 09-03-03 and 09-05-03. Review of the reconsideration HCFA's reflected proof of submission for dates of service 09-02-03, 09-03-03 and 09-05-03, however per Rule 134.202 (b) code 97010 is invalid. No reimbursement recommended.

Review of the requestor's and respondent's documentation revealed that neither party submitted a copy of the EOB for CPT code 99214 for date of service 09-04-03. Review of the reconsideration HCFA's reflected proof of submission for date of service 09-04-03. Reimbursement per the Medical Fee Guideline effective 08-01-03 is \$103.24. The requestor only billed \$71.00 for this service and therefore reimbursement in the amount of \$71.00 is recommended.

Review of the requestor's and respondent's documentation revealed that neither party submitted a copy of the EOB for CPT code 99080-73 for date of service 09-04-03. Review of the reconsideration HCFA's reflected proof of submission for date of service 09-04-03. Reimbursement is recommended in the amount of \$15.00.

Total reimbursement of \$195.23 for the fee issues is recommended.

This Findings and Decision is hereby issued this 5<sup>th</sup> day of October 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

## ORDER

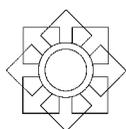
Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 02-24-03 through 09-05-03 in this dispute.

This Order is hereby issued this 5th day of October 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/dlh

Enclosure: IRO Decision



## Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South •  
Austin, Texas 78746-5799  
phone 512-329-6610 • fax 512-327-7159 • [www.tmf.org](http://www.tmf.org)

### NOTICE OF INDEPENDENT REVIEW DECISION

March 4, 2004

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

RE: Injured Worker: \_\_\_\_\_  
MDR Tracking #: M5-04-1121-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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. TMF'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 TMF 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 \_\_\_\_ when he was struck by some rebar to the lateral aspect of his right knee. On 10/22/02, he underwent a right anterior cruciate ligament reconstruction, partial medial meniscectomy, and lateral meniscus repair. He went through a course of physical therapy post operatively and then saw a chiropractor for ongoing treatment.

### Requested Service(s)

Office visits-established patient, therapeutic activities, therapeutic exercises, ultrasound therapy, gait training, electrical stimulation-unattended, special reports, hot/cold pack therapy, and electrical stimulation from 02/24/03 through 09/26/03

### Decision

It is determined that the therapeutic activities, therapeutic exercises, gait training, and special reports from 02/24/03 through 06/01/03 were medically necessary to treat this patient's condition. However, office visits-established patient, ultrasound therapy, electrical stimulation, hot/cold pack therapy, and electrical stimulation-unattended from 02/24/03 through 09/26/03 were not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The medical records provided show that the patient was having difficulty gaining flexion over the right knee following surgery on 10/22/02. Courses of physical therapy were requested on numerous occasions by the treating surgeon and it was reasonable to proceed with the therapy requested. It is not reasonable to treat the patient with a passive algorithm for nearly six months. Treatment of this patient's medical condition within a passive therapeutic algorithm is not appropriate and does not provide an effective transition to active, patient-driven therapeutics, which are medically necessitated. Failure to transition this patient in an expeditious manner

out of the passive therapeutic algorithm fosters dependence of passive clinical therapeutics which is a counter productive outcome in any return to function program.

The provider has not implemented qualitative/quantitative tools to document the efficacy of his therapeutic applications. It is not clear why a baseline of current function (Functional Capacity Evaluation) was not implemented during the management of this patient from 02/24/03 through 09/26/03. It is vital to the management of this patient's condition that passive therapeutics cease and an active, patient-driven therapeutic model be adopted. The patient appears to have some residual impairment of function over the right knee and it must be determined if this patient is a candidate for upper level therapeutics.

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

- Durand A, et al. *Strength recovery and muscle activation of the knee extensor and flexor muscles after arthroscopic meniscectomy: A pilot study.* Clin Orthop. 1991 Jan;(262):210-26.
- Malone T, et al. *Muscular control of the patella.* Clin Sports Med. 202 Jul;21(3):349-62.
- Matthews P, et al. *Recovery of muscle strength following arthroscopic meniscectomy.* J Orthop Sports Phys Ther. 1996 Jan;23(1):18-26.
- *Overview of implementation of outcome assessment case management in the clinical practice.* Washington State Chiropractic Association; 2001. 54p.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." The signature is written in a cursive, somewhat stylized font.

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:vn