

MDR Tracking Number: M5-04-1123-01

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, therapeutic exercises, therapeutic activities, neuromuscular re-education, myofascial release, manual traction, unlisted therapeutic procedure rendered from 03-31-03 through 07-08-03 that were denied based "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 03-17-04, 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\$	Reference	Rationale
02-19-03	97110	\$150.00 (3 units)	\$35.00	F	\$35.00	Rule 133.307 (G)(3)(A-F)	See rationale below. No additional reimbursement recommended.
02-21-03	97110	\$140.00 (3 units)	\$35.00	D	\$35.00	Rule 133.307 (G)(3)(A-F)	See rationale below. No additional reimbursement recommended.
02-19-03	97530	\$183.00 (3 units)	\$35.00	F	\$35.00	Rule 133.307 (G)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No additional

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
							reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
02-21-03	97530	\$244.00 (4 units)	\$35.00	D	\$35.00	Rule 133.307 (G)(3)(A-F)	Requestor nor respondent provided original denial information. Denial reason cannot be determined. No additional reimbursement recommended.
03-27-03	97530	\$105.00 (3 units)	\$43.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No additional reimbursement recommended.
02-19-03	99213	\$93.00 (1 unit)	\$48.00	F	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No additional reimbursement recommended.
03-27-03	99213	\$55.00 (1 unit)	\$48.00	NO EOB	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No additional reimbursement recommended.
02-21-03	97250	\$58.00 (1 unit)	\$43.00	D	\$43.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent provided original denial information. Denial reason cannot be determined. No additional reimbursement

							recommended.
09-19-03	97250	\$58.00 (1 unit)	\$43.00	NO EOB	\$30.90 MEDICARE FEE SCHEDULE	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No additional reimbursement recommended.
04-25-03	97545- WH	\$130.00	\$102.40	NO EOB	\$64.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No additional reimbursement recommended.
04-25-03	97546- WH	\$100.00	\$51.20	D	\$64.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent provided original denial information. Denial reason cannot be determined. No additional reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
04-25-03	97546- WH	\$400.00 (\$100.00 X 4)	\$204.80 (\$51.20 X 4)	NO EOB	\$64.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No additional reimbursement recommended.
06-10-03	99455- L4	\$450.00 (\$150.00 X 3)	\$0.00	F	DOP	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
TOTAL		\$2,166.00	\$723.40				Requestor is not entitled to any reimbursement.

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 dates of service 03-31-03 through 07-08-03 in this dispute.

This Findings and Decision and Order are hereby issued this 3rd day of June 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

March 16, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1123-01

___ 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 female who sustained a work related injury on ____. The patient reported that while at work she fell injuring her back, legs, right shoulder and right hand. On 1/30/03 the patient underwent x-rays of her back that showed an anterior wedge compression fracture of T11 vertebral body and narrowing of the disc space at T10 and T11. A MRI of the right shoulder dated 2/24/03 indicated marked thickening of the supraspinatus tendon and an inferior margin glenoid labrum tear with a small paralabral cyst. The diagnoses for this patient have included rotator cuff syndrome, contusion of knee, lumbar sprain and strain, and closed thoracic dislocation. The patient was initially treated with chiropractic care that consisted of therapeutic exercises, therapeutic activities, myofascial release, manipulations, neuromuscular reeducation, and manual traction. The patient had also participated in a work hardening program.

Requested Services

Office visits, therapeutic exercises, therapeutic activities, neuromuscular reeducation, myofascial release, manual traction, unlisted therapeutic procedure from 3/31/03 through 7/8/03.

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 case concerns a female who sustained a work related injury to her back, legs, right shoulder and right hand on ____. The ___ chiropractor reviewer indicated that this patient had a multi faceted diagnosis of several areas of her body making her condition a complicated case for treatment. The ___ chiropractor reviewer noted that the patient made steady progress from 3/13/03 through 4/30/03. The ___ chiropractor reviewer also noted that the patient underwent a work hardening program that initially caused the patient pain, but eventually helped increase her strength. The ___ chiropractor reviewer further noted that the ultimately the patient was better by the end of treatment on 7/23/03. The ___ chiropractor reviewer explained that the patient was returned to her regular job after being deemed at maximum medical improvement with a 6% whole person impairment. The ___ chiropractor reviewer further explained that care that relieves symptoms and aids in the return to work is medically necessary. Therefore, the ___ chiropractor consultant concluded that the office visits, therapeutic exercises, therapeutic activities, neuromuscular reeducation, myofascial release, manual traction, unlisted therapeutic procedure from 3/31/03 through 7/8/03 were medically necessary to treat this patient's condition.

Sincerely,