

MDR Tracking Number: M5-04-1294-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 January 8, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. The office visits, therapeutic exercises, myofascial release, ultrasound therapy, electric stimulation unattended, hot/cold pack therapy, reports, and office visits evaluation and management established patient from 01-22-03 through 04-02-03. 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On March 22, 2004, 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\$ (Max. Allowable Reimbursement)	Reference	Rationale
03-26-03 03-28-03 03-31-03	97110	\$40.00 \$40.00 \$40.00	\$0.00	R	\$35.00	1996 MFG	See Rationale below for 97110.
03-26-03 03-28-03 03-31-03	99213	\$60.00 \$60.00 \$60.00	\$0.00	R	\$48.00	1996 MFG	According to TWCC database, all compensability issues regarding this claim have been resolved. Therefore, the disputed services will be addressed according to the 1996 MFG Schedule. Recommend payment of \$144.00.
TOTAL							The requestor is entitled to reimbursement of \$144.00

Rationale for CPT code 97110- 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 has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended

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 Order is applicable for dates of service 01-22-03 through 04-02-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 10th day of October 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

March 19, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-04-1294-01
IRO Certificate #: 5348**

___ 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 54 year-old male who sustained a work related injury on ____. The patient reported that while at work he was attempting to pull a patient onto a stretcher when he injured his low back. A initial evaluation note dated 8/1/02 from the treating doctor indicated that the patient was initially treated with medications and approximately two weeks of physical therapy. It also indicated that the patient was scheduled for back surgery consisting of lumbar fusion. It further indicated that MRI films dated 8/30/01 showed dessiccation of the discs at T10-T11, L3, L4, and L5, posterior annular bulging of all levels indicated, and possible herniation at the L4-L5 level. The patient was continued on a physical therapy program consisting of heat, soft tissue mobilization, ultrasound, hot/cold pack, neuromuscular stimulation, and a lumbar support belt. 11/19/02 the patient underwent a MRI of the thoracic spine that indicated small central disc herniation at T6-7. On 12/2/02 the patient was evaluated by a pain management specialist and underwent an EMG/NCV of the lower extremities that indicated facet joint arthropathy at L3-L4 and L4-L5. The patient was then further treated with a series of epidural injections and nerve root block at left T10 and continued therapy. The patient has also undergone individual counseling sessions with biofeedback.

Requested Services

Office visits, therapeutic exercises, myofascial release, ultrasound therapy, electric stimulation unattended, hot/cold pack therapy, reports, office visits eval/mgmt established patient from 1/22/03 through 4/2/03.

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 54 year-old male who sustained a work related injury to his low back on ____. The ___ chiropractor reviewer also noted that a MRI films dated 8/30/01 showed dessiccation of the discs at T10-T11, L3, L4, and L5, posterior annular bulging of all levels indicated and possible herniation at the L4-L5 levels. The ___ chiropractor reviewer further noted that treatment for this patient's condition had included physical therapy program consisting of heat, soft tissue mobilization, ultrasound, hot/cold pack, neuromuscular stimulation, and a lumbar support belt. The ___ chiropractor reviewer indicated that the patient had undergone a back surgery. However, the ___ chiropractor reviewer explained that the back surgery was rescheduled several times before it took place. The ___ chiropractor reviewer explained that due to the extensive injuries sustained by this patient supported by diagnostic findings, and the delay in undergoing back surgery, the treatment

between 1/22/03 through 4/2/03 was medically necessary. Therefore, the ___ chiropractor consultant concluded that the office visits, therapeutic exercises, myofascial release, ultrasound therapy, electric stimulation unattended, hot/cold pack therapy, reports, office visits eval/mgmt established patient from 1/22/03 through 4/2/03 were medically necessary to treat this patient's condition.

Sincerely,