

MDR Tracking Number: M5-04-1376-01

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 01-16-04.

The IRO reviewed neuromuscular re-education, therapeutic exercises, manual therapy, aquatic therapy, mechanical traction, electric stimulation, office visit consult-new or established patient, office visit, myofascial release, chiropractic manipulative treatment (CMT) spinal 1 to 2 regions, CMT spinal 3 to 4 areas and CMT extraspinal 1 or more regions rendered from 07-28-03 through 11-04-03 that was denied based upon "V".

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

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 04-13-04, 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
9-6-03 through 10-8-03 (3 DOS)	97112	\$328.00 (2 units @ \$82.00 X 1 DOS and 3 units @ \$123.00 X 2 DOS	\$0.00	NO EOB	\$36.94 per unit	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
9-6-03 through 10-8-03 (3 DOS)	97110	\$280.00 (2 units @ \$80.00 X 2 DOS and 3 units @ \$120.00 X 1 DOS)	\$0.00	NO EOB	\$35.90 per unit	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
9-6-03 through 10-8-03 (4 DOS)	98943	\$200.00 (1 unit @ \$50.00 X 4 DOS)	\$0.00	NO EOB	\$29.41 per unit	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
9-6-03 through 9-26-03 (3 DOS)	97140	\$120.00 (1 unit @ \$40.00 X 3 DOS)	\$0.00	NO EOB	\$34.05 per unit	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
9-6-03 through 10-8-03 (3 DOS)	98940	\$120.00 (1 unit @ \$40.00 X 3 DOS)	\$0.00	NO EOB	\$27.69 per unit	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
9-23-03	97113	\$45.00 (1 unit)	\$0.00	NO EOB	\$38.38	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
TOTAL		\$1,093.00	\$0.00				The 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.

This Findings and Decision is hereby issued this 29<sup>th</sup> day of April 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division  
DLH/dlh

April 13, 2004

NOTICE OF INDEPENDENT REVIEW DECISION  
Amended Letter

RE: MDR Tracking #: M5-04-1376-01

\_\_\_ 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 31 year-old female who sustained a work related injury on \_\_\_. The patient reported that while at work doing data entry, she began to experience the gradual onset of increasing pain in both wrists. The patient underwent MRIs of both wrists and the cervical spine on 4/29/03 that showed evidence of a mild degree of "crowding" of the flexor tendons within the carpal tunnel and anterior bowing of the flexor retinaculum reflecting clinical carpal tunnel syndrome in the wrists, and evidence of cervical lordosis straightening reflecting musculature pain and spasm in the cervical spine. The patient underwent an NCV/EMG on 5/20/03. On 12/2/03 the patient underwent left wrist endoscopic carpal tunnel release. Further treatment for this patient's condition has included injections to both wrists, neuromuscular reeducation, therapeutic exercises, manual therapy, aquatic therapy, mechanical traction, electric stimulation, myofascial release, and chiropractic manipulative treatment.

The diagnoses for this patient have included closed dislocation of wrist, unspecified part, median nerve with radiculitis, radial styloid tenosynovitis, and displacement of cervical intervertebral disc without myelopathy.

#### Requested Services

Neuromuscular reeducation, therapeutic exercises, manual therapy, aquatic therapy, mechanical traction, electric stimulation, office visit consult-new or established patient, office visit, myofascial release, chiropractic manipulative treatment (CMT) spinal 1 to 2 regions, CMT spinal 3 to 4 areas, CMT extraspinal, 1 or more regions from 7/28/03 through 11/04/03.

#### Decision

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

#### Rationale/Basis for Decision

The \_\_\_chiropractor reviewer noted that this case concerns a 31 year-old female who sustained a work related injury to both her wrists on \_\_\_\_. The \_\_\_chiropractor reviewer indicated that the patient has a compression on the carpal tunnel. The \_\_\_chiropractor reviewer explained that 6-8 weeks of conservative care would be appropriated if the patient showed signs of improvement. The \_\_\_chiropractor reviewer also explained that there is no documented improvement in the patient's condition after treatment with multiple injections and various therapies. The \_\_\_chiropractor reviewer indicated that there is no medical necessity in continuing therapy that is showing no subjective or objective improvement. The \_\_\_chiropractor reviewer explained that it was determined that the patient required surgery in June and that is could have been performed in August. However, the \_\_\_chiropractor reviewer explained that the surgery was not performed until December. Therefore, the \_\_\_chiropractor consultant concluded that the neuromuscular reeducation, therapeutic exercises, manual therapy, aquatic therapy, mechanical traction, electric stimulation, office visit consult-new or established patient, office visit, myofascial release, chiropractic manipulative treatment (CMT) spinal 1 to 2 regions, CMT spinal 3 to 4 areas, and CMT extraspinal, 1 or more regions from 7/28/03 through 11/04/03 were not medically necessary to treat this patient.

Sincerely,