

MDR Tracking Number: M5-04-1609-01

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 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on February 4, 2004.

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. The joint mobilization, myofascial release, therapeutic exercises, manual therapy technique, and gait training rendered on 7/14/03 through 10/23/03 were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 5, 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	Rationale
9/15/03	97110 x 3	\$107.70	\$0.00	No EOBs	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 the one-on-one therapy 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.
9/17/03	97110 x 3	\$107.70	\$0.00		
9/18/03	97110 x 3	\$107.70	\$0.00		
TOTAL		\$323.10	\$0.00		

## ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 to dates of service 7/14/03 through 10/23/03 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 8<sup>th</sup> day of October 2004.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division

MQO/mqo

June 10, 2004

### **NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-04-1609-01**  
**IRO Certificate #: 5348**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The \_\_\_ 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 who is familiar with the with the condition and treatment options at issue in this appeal. 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 male who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work he tripped over a metal rack and injured his left foot. The diagnoses for this patient included comminuted fracture of the 5<sup>th</sup> metatarsal. The patient was placed in a rigid brace for 8 weeks and on 5/8/03 the patient began therapy through 10/24/03. The patient was also treated with a work hardening program.

Requested Services

Joint mobil, myoras rel, ther exer, man ther tech, gait training from 7/14/03 through 10/23/03.

Documents and/or information used by the reviewer to reach a decision:

*Documents Submitted by Requestor:*

1. Introduction
2. Progress notes 7/14/03 – 10/23/03
3. Work Hardening daily notes 9/15/03 – 10/24/03

*Documents Submitted by Respondent:*

1. No documents submitted

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 male who sustained a work related injury to his left foot on \_\_\_\_\_. The \_\_\_\_ chiropractor reviewer also noted that the diagnoses for this patient have included comminuted fracture of the 5<sup>th</sup> metatarsal. The \_\_\_\_ chiropractor reviewer further noted that this patient was placed in a rigid brace for 8 weeks followed by therapy and a work hardening program. The \_\_\_\_ chiropractor reviewer explained that this patient's injury required treatment. The \_\_\_\_ chiropractor reviewer also explained that the treatment this patient received was both medically necessary and appropriated for his condition. Therefore, the \_\_\_\_ chiropractor consultant concluded that the joint mobil, myoras rel, ther exer, man ther tech, gait training from 7/14/03 through 10/23/03 were medically necessary to treat this patient's condition.

Sincerely,