

MDR Tracking Number: M5-04-1702-01

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 May 9, 2003.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. The neuromuscular re-education, gait training, therapeutic exercises, and therapeutic procedures that were denied with “U” from 08-15-02 through 09-25-02 were found to be medically necessary. 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 May 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	MARS (Max. Allowable Reimbursement)	Reference	Rationale
08-16-02	99213	\$45.00	\$0	N	\$48.00	1996 Medical Fee Guideline	The requestor submitted relevant information to support documentation criteria and delivery of service. Therefore, 99213 will be reviewed in accordance with the 1996 MFG. Recommend reimbursement of \$48.00.
08-21-02	97116	\$38.00	\$0	N	\$38.00	1996 Medical Fee Guideline	The requestor submitted relevant information to support documentation criteria and delivery of service. Therefore, 97116 will be reviewed in accordance with the 1996 MFG. Recommend reimbursement of \$38.00.

05-13-02	99204	\$150.00	\$0	N	\$106.00	1996 Medical Fee Guideline	The requestor submitted relevant information to support documentation criteria and delivery of service. Therefore, 99204 will be reviewed in accordance with the 1996 MFG. Recommend reimbursement of \$106.00
05-14-02 through 06-18-02	97250	\$731.00 17 units	\$0	N	\$43.00/unit x 17	1996 Medical Fee Guideline	The requestor submitted relevant information to support documentation criteria and delivery of service. Therefore, 97250 will be reviewed in accordance with the 1996 MFG. Recommend reimbursement of \$731.00.
05-20-02 05-21-02 05-22-02 05-23-02 05-24-02 05-28-02 05-29-02 05-30-02 06-03-02 06-05-02 06-07-02 06-10-02 06-11-02 06-14-02 06-17-02 06-18-02 06-27-02 06-28-02 07-01-02 07-02-02 07-03-02 07-09-02 07-11-02 07-16-02 07-17-02 07-18-02 07-23-02 07-24-02 07-25-02 07-31-02 08-01-02 08-07-02	97112 x4 97112 x4 97112 x4 97112 x5 97112 x5 97112 x3 97112 x3 97112 x3 97112 x3 97112 x3 97112 x3 97112 x2 97112 x2 97112 x3 97112 x2 97112 x2 97112 x2 97112 x2 97112 x2 97112 x2 97112 x3 97112 x1 97112 x1 97112 x2 97112 x2 97112 x2 97112 x1 97112 x2 97112 x1 97112 x1 97112 x1 97112 x1 97112 x2 97112 x1	\$140.00 \$140.00 \$140.00 \$175.00 \$175.00 \$105.00 \$105.00 \$105.00 \$105.00 \$105.00 \$105.00 \$70.00 \$70.00 \$105.00 \$70.00 \$70.00 \$70.00 \$70.00 \$70.00 \$70.00 \$105.00 \$35.00 \$35.00 \$70.00 \$70.00 \$70.00 \$35.00 \$35.00 \$35.00 \$35.00 \$35.00 \$35.00 \$70.00 \$35.00	\$70.00 \$70.00 \$70.00 \$70.00 \$70.00 \$0.00	N	\$35.00/unit	1996 Medical Fee Guideline	The requestor submitted relevant information to support documentation criteria and delivery of service. Therefore, 97112 will be reviewed in accordance with the 1996 MFG. Recommend additional reimbursement of \$2345.00
05-28-04	97110 (116units)	\$4060.00	\$1120.00	N	\$35.00/unit x 116 units	1996 Medical Fee Guideline	See Rationale below for CPT code 97110.
06-27-02	97010	\$15.00	\$0.00	N	\$11.00	1996 Medical Fee Guideline	The requestor submitted relevant information to support documentation criteria and delivery of service. Therefore, 97010 will be reviewed in accordance with the 1996 MFG. Recommend reimbursement of \$11.00
TOTAL		\$7769.00					The requestor is entitled to reimbursement of \$3279.00.

Rationale for CPT code 97110 - Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section 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.

This Findings and Decision is hereby issued this 29th day of October 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

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 05-13-02 through 09-25-02 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 29th day of October 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/pr

April 27, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1702-01

___ 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. 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 50 year-old male who sustained a work related injury on ___. The patient reported that while at work he slipped and fell injuring his left knee and fracturing his right rib. An MRI of the left knee dated 5/22/02 showed no evidence of a meniscal tear or cruciate ligament disruption. Initial treatment for this patient's condition included passive physical therapy and medications for the diagnoses of status post fall, right rib fracture and medial meniscal tear left knee. On 6/19/02 the patient underwent a partial medial and lateral meniscectomy left knee, chondroplasty weight bearing surface medial femoral condyle, and insertion of a PCA pump for postoperative analgesia through a separate superolateral incisional portal. On 6/21/02 the patient's PCA pump was discontinued and the patient was referred for active physical therapy consisting of gait training, manual therapy, mobility exercises, neuromuscular reeducation, stabilization exercises, and strengthening exercises.

Requested Services

Neuro reeducation, gait train, therapeutic activities, therapeutic exercises, and therapeutic procedures from 8/15/02 through 9/25/02.

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 ___ physician reviewer noted that this case concerns a 50 year-old male who sustained a work related injury to his left knee and right rib on ___. The ___ chiropractor reviewer also

noted that the diagnoses for this patient have included right rib fracture and medial meniscal tear of the left knee. The ___ chiropractor reviewer further noted that the patient had undergone a partial medial and lateral meniscectomy left knee, chondroplasty weight bearing surface medial femoral condyle, and insertion of a PCA pump for postoperative analgesia on 6/19/02 followed by active physical therapy. The ___ chiropractor reviewer explained that the treatment rendered to this patient was appropriate for his diagnoses. The ___ chiropractor reviewer also explained that the patient has made progress with treatment rendered. Therefore, the ___ chiropractor consultant concluded that the neuro reeducation, gait train, therapeutic activities, therapeutic exercises, and therapeutic procedures from 8/15/02 through 9/25/02 were medically necessary to treat this patient's condition at this time.

Sincerely,