

MDR Tracking Number: M5-04-1823-01

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 February 20, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. The subsequent visit, therapeutic exercised, manual therapy, unlisted procedure, ROM measurements, therapeutic activities, neuromuscular reeducation, and electrical stimulation from 08-20-03 through 11-26-03 **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 13, 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
10-10-03	95851	\$39.39	\$0.00	No EOB	\$35.78	Medicare Fee Guideline 134.202	Requestor submitted proof of reconsideration in accordance with rule 133.307(e)(2)(B) for services billed. Recommend reimbursement of \$35.78
10-15-03	97110 x4	\$136.20	\$0.00	O	\$35.90/unit	Medicare Fee Guideline 134.202	See Rationale for 97110 below.
10-17-03	99212 97110 x4	\$47.23 \$136.20	\$0.00 \$0.00	No EOB	\$47.23 \$35.90/unit	Medicare Fee Guideline 134.202	CPT code 99212 was billed by the requestor and denied by the carrier. Neither the requestor nor the respondents submitted EOB's. The 99212 service rendered on 10-17-03 will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the

							denial of this service, reimbursement is recommended in the amount of \$47.23 See Rationale for 97110 below.
10-20-03	97110 x4	\$136.20	\$0.00	No EOB	\$35.90/unit	Medicare Fee Guideline 134.202	See Rationale for 97110 below.
10-22-03	97110 x4	\$136.20	\$0.00	No EOB	\$35.90/unit	Medicare Fee Guideline 134.202	See Rationale for 97110 below.
10-24-03	99212 97110 x4	\$47.23 \$136.20	\$0.00 \$0.00	N F	\$47.23 \$35.90/unit	Medicare Fee Guideline 134.202	The requestor submitted relevant information that meets the documentation criteria. Recommend reimbursement of \$47.23. See Rationale for 97110 below.
10-29-03	97110 x4	\$136.20	\$0.00	F	\$35.90/unit	Medicare Fee Guideline 134.202	See Rationale for 97110 below.
10-31-03	95851	\$35.78	\$0.00	F	\$35.78	Medicare Fee Guideline 134.202	Requestor submitted relevant information to support services billed. Recommend reimbursement of \$35.78.
10-31-03	97110 x4	\$136.20	\$0.00	F	\$35.90/unit	Medicare Fee Guideline 134.202	See Rationale for 97110 below.
TOTAL		\$1123.03					The requestor is entitled to reimbursement of \$166.02.

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.

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 Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); 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 08-20-03 through 11-26-03 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 22nd day of October 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

May 11, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter**

RE: MDR Tracking #: M5-04-1823-01

___ 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 physician 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. This physician is board certified in physical medicine and rehabilitation. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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 ___ physician 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 slipped and fell from a ladder inuring his right knee. An MRI of the right knee indicated a possible proximal partial tear of the anterior cruciate ligament, mild buckling of posterior cruciate ligament, no meniscal tear, mild degenerative changes bilaterally, and a small effusion. On 9/23/03 the patient underwent a right knee arthroscopy, examination under anesthesia, anterior cruciate ligament repair using electrothermal modification, posterior cruciate ligament repair of the tear, partial, electrothermal modification, partial meniscectomy, medial meniscus posterior horn and lateral meniscus anterior horn, and placement of a pain

pump. Preoperative treatment had included passive rehabilitation. Postoperatively, the patient was treated with rehabilitation that included cardiovascular training and therapeutic exercises.

Requested Services

Subsequent visit, exercises, manual therapy, unlisted procedure, ROM measurements, therapeutic activities, neuromuscular reeducation and stimulation from 8/20/03 through 11/26/03.

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 ___ physician reviewer noted that this case concerns a male who sustained a work related injury to his left knee on ___. The ___ physician reviewer also noted that the documents provided contained only right lower extremity strength range of motion testing of the right knee flexion. However, the ___ physician reviewer indicated that the patient's knee range of motion (flexion) improved from 68 degrees to 121 degrees between the dates in question. The ___ physician reviewer noted that the patient's pain level remained between 4-5/10, but that his endurance to perform activities had improved. The ___ physician also explained that although patient appeared to have experienced an exacerbation of pain on 10/22/03 (5/10), the patient was continued with conservative modalities and reported a decrease in pain (3/10). The ___ physician reviewer noted that the patient continued with more active rehabilitation and that he was geared more towards neuromuscular reeducation, ambulation, and therapeutic exercises. The ___ physician reviewer explained that although the patient's pain level was a 3/10 as of 11/26/03, the physical therapy treatments this patient received were medically necessary to attempt to decrease pain and improve function in the right knee. Therefore, the ___ physician consultant concluded that the subsequent visit, exercises, manual therapy, unlisted procedure, ROM measurements, therapeutic activities, neuromuscular reeducation and stimulation from 8/20/03 through 11/26/03 were medically necessary to treat this patient's condition.

Sincerely,