MDR Tracking Number: M5-04-2004-01

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 3-5-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement 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.

The application modality, office outpatient visit E&M low mod severity, joint mobilization, myofascial release, therapeutic procedure, physical performance test, special reports and range of measurement report from 4-21-03 through 5-30-03 **were found** to be medically necessary. The application modality, office outpatient visit E&M low mod severity, joint mobilization, myofascial release, therapeutic procedure, physical performance test, special reports and range of measurement report from 6-2-03 through 7-29-03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The requestor submitted a revised Table of Disputed Services on 12-2-04. They withdrew the following items: CPT codes 97150 and 97110 on 6-12-03, CPT codes 97110 and 97150 on 6-13-03 99080 on 6-27-03 and 99213 on 6-16-03 and 6-30-03.

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 6-3-04, the Medical Review Division submitted a Notice to the 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.

Regarding CPT Codes 97750-MT, 99213, 97265, 97250, 97150 and 99080 for dos 6-11-03 through 7-2-03 and CPT code 99213 for 7-22-03: Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's. However the Carrier’s response to the Requestor’s additional documentation included the missing EOB’s. The Carrier denied reimbursement as “V” – unnecessary treatment with peer review. The Carrier has had ample opportunity to supply EOB’s to the Requestor prior to their filing for medical dispute resolution and assignment to an IRO; therefore the disputed services will be reviewed according to the 1996 Fee Guidelines since the requester submitted "convincing evidence of the carrier's receipt of the provider request for an EOB" according to 133.307 (e)(2)(B). Recommend reimbursement for these services as outlined below:

- CPT code 97750-MT – 9 units x $43.00 = $387.00
- CPT code 99213 – 6 dos x $48.00 = $288.00
- CPT code 97265 – 8 dos x $43.00 = $344.00
- CPT code 97250 – 8 dos x $43.00 = $344.00
- CPT code 97150 – 4 dos x $27.00 = $108.00

- CPT code 99080-73 for date of service 7-8-03 was denied by the respondent with a "V" denial code for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requester submitted relevant information to support delivery of service. Per 129.5 **recommend reimbursement of CPT Code 99080-73 for $15.00.**

- CPT code 97110 for dates of service 6-6-03, 6-16-03, 6-18-03, 6-20-03, 6-30-03, 7-1-03: 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 Finding and Decision is hereby issued this ____8th____ day of December, 2004.

Medical Dispute Resolution Officer
Medical Review Division

Pursuant to 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) for dates of service through July 31, 2003; 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 4-21-03 through 7-22-03 as outlined above 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 ____8th____ day of December, 2004.

R. L., Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

May 14, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2004-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ 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 37 year-old male who sustained a work related injury on ------. The patient reported that while at work he slipped and fell, injuring his right leg, right knee, and lower back. The patient was initially evaluated and underwent x-rays that demonstrated a right fractured fibula, and placed in a splint for the fractured lateral malleolus. On 3/31/03 the patient was placed in a fiberglass cast just below the knee and on 4/21/03 the patient began a course of physical therapy. The patient's cast was removed on 5/15/03 and on 5/19/03 the patient began an office supervised therapeutic exercise program. The patient continued physical therapy and chiropractic treatments. The diagnoses for this patient have included fracture of the right fibula, right knee sprain/strain, grade II, lumbar sprain/strain, grade II, and myofascial pain syndrome.

Requested Services

Applic modal, office outpatient visit E&M low mod severity, joint mobilization, myofascial release, therapeutic procedure, phys performance test, spec reports and range of measurement report from 4/21/03 through 7/29/03.

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

Documents Submitted by Requestor:

1. Letter 4/14/04
2. SOAP notes 3/31/03 – 9/24/03
3. Therapeutic procedure notes 5/19/03-7/2/03
4. Initial Medical Narrative Report 3/31/03

Documents Submitted by Respondent:

1. Response to IRO request for records 4/14/04
2. Office note 8/1/03
3. SOAP notes 3/31/03 – 7/29/03

Decision

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

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a 37 year-old male who sustained a work related injury to his right leg, right knee, and lower back on ------. The ------ chiropractor reviewer also noted that the diagnoses for this patient have included fracture of the right fibula, right knee sprain/strain, grade II, lumbar sprain/strain, grade II, and myofascial pain syndrome. The ------ chiropractor reviewer further noted that treatment for this patient's condition has included casting of the right fibula and rehabilitation that consisted of joint mobilization, myofascial release, and therapeutic procedures. The ------ chiropractor reviewer indicated that the patient failed to demonstrate and objective or subjective improvement in his condition. The ------ chiropractor reviewer explained that after 5/30/03 the patient's pain was negligible and that the patient's injury could have been self limiting and resolve on its own with an active home therapy program. The ------ chiropractor reviewer also explained that there is no medical necessity shown for the extensive treatment this patient received. The ------ chiropractor reviewer explained that a muscle strength testing is not indicative of the patient's overall response to care and ability to return to work. The ------ chiropractor reviewer further explained that this patient failed to show favorable results with treatment rendered. Therefore, the ------ chiropractor consultant concluded that the applic modal, office outpatient visit E&M low mod severity, joint mobilization, myofascial release, therapeutic procedure, phys performance test, spec reports and range of measurement report from 4/21/03 through 5/30/03 were medically necessary to treat this patient's condition. However, the ------ chiropractor consultant further concluded that the applic modal, office outpatient visit E&M low mod severity, joint mobilization, myofascial release, therapeutic procedure, phys performance test, spec reports and range of measurement report from 6/2/03 through 7/29/03 were not medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department