

THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-04-5344.M5

Amended MDR Tracking Number: M5-04-2227-01 (**Previously M5-03-2936-01**)

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 July 14, 2003.

This AMENDED FINDINGS AND DECISION supersedes all previous Decisions rendered in this Medical Payment Dispute involving the above requestor and respondent.

The Medical Review Division's Decision of February 13, 2004 was appealed and subsequently withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of March 23, 2004. An Order was rendered in favor of the Requestor. The Requestor appealed the Order to an Administrative Hearing because the calculations in the table were erroneous. The reviewer inadvertently omitted a fee reimbursement of \$106.00 for date of service 1/17/03.

The IRO reviewed 97265, 97110 for DOS 1/28/03, 1/30/03 through 2/11/03; 2/3/03 CPT code 95999-WP and 97265; 2/13/03 through 4/7/03 denied based upon "U".

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 \$650.00** 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. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On September 15, 2003, 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.

Both the requestor and respondent failed to submit copies of EOBs for several dates of service. Therefore the disputed charges with no EOBs will be reviewed according to the Medical Fee Guideline.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
1/27/03	99204	\$106.00	\$0.00	N	\$106.00	<u>MFG, Evaluation/Management Ground Rule (VI)(A)</u> CPT code descriptor	The office visit note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$106.00.
1/28/03	L1906 AFO, multiligamentous ankle support	\$49.00	\$19.95	M	DOP	<u>MFG, General Instructions Ground Rule (III) & (VI)</u> HCPCS descriptor	The requestor did not submit relevant information to support additional reimbursement of the DOP code. Additional reimbursement is not recommended.
1/30/03	97110	\$175.00	\$140.00	F	\$175.00	<u>MFG, Medicine Ground Rule (I)(A)(9)(b), (I)(A)(10)(a) & (I)(A)(11)(a)</u> Section 413.016 CPT code descriptor	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 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 because the office note did not clearly delineate the
2/4/03	97110	\$175.00	\$140.00	F	\$175.00		
2/6/03	97110	\$175.00	\$140.00	F	\$175.00		
2/7/03	97110	\$175.00	\$140.00	F	\$175.00		
2/11/03	97110	\$175.00	\$140.00	F	\$175.00		
2/18/03	97110	\$175.00	\$140.00	F	\$175.00		
2/12/03	97110	\$175.00	\$140.00	No EOB	\$175.00		
3/4/03	97110	\$175.00	\$140.00	No EOB	\$175.00		

							severity of the injury to warrant exclusive one-to-one treatment. Reimbursement is not recommended.
2/4/03	97550-MT	\$86.00	\$0.00	F	\$43.00	<u>MFG, Medicine Ground Rule (I)(C)(1)(b)</u>	Review of the "F.O.C.U.S. Custom Report", dated 2/4/03 supports delivery of service. The requestor is therefore entitled to reimbursement in the amount of \$43.00.
2/11/03	L1906 AFO, multiligamentous ankle support	\$49.00	\$0.00	N	DOP	<u>MFG, General Instructions Ground Rule (III) & (VI)</u> HCPCS descriptor	Review of the office note, does not document that an AFO, multiligamentous ankle support was supplied to the injured worker on this date. Therefore the requestor is not entitled to reimbursement of the disputed charge.
2/12/03	97139	\$85.00	\$24.75	M	DOP	<u>MFG, Medicine Ground Rule (I)(C)(1)(q) (I)(A)(9)(b) & (I)(A)(10)(a)</u> CPT code descriptor	Per CPT code descriptor, 97139 is an unlisted therapeutic procedure, which requires specificity by the use of a modifier. The table of disputed services does not "specify" what unlisted therapeutic procedure was performed. The requestor has not identified on the Table of disputed service what charge is in dispute in order to address to "M" denial from the carrier. Therefore, additional reimbursement is not recommended.
2/12/03	97265	\$43.00	\$0.00	No EOB	\$43.00	Rule 133.307	Review of the office note supports delivery of service. Reimbursement is recommended in the amount of \$43.00.
2/12/03	73721-22-27	\$756.00	\$0.00	F	\$756.00	<u>MFG, Radiology/ Nuclear Medicine Ground Rule (I)(A)(4), (II)(C)(3)</u>	Review of the radiology report, dated 2/12/03 supports delivery of service; the requestor is therefore entitled to reimbursement in the amount of \$756.00.
2/27/03	95851	\$72.00	\$0.00	G	\$36.00	<u>MFG, Medicine Ground Rule (I)(E)(4)</u>	Review of the "F.O.C.U.S. Custom Report", dated 2/27/03 does not reflect that CPT code 95851 is global to any other service billed

							prior to 2/27/03, on 2/27/03 and after 2/27/03. The requestor is therefore entitled to reimbursement in the amount of \$36.00.
3/4/03	97265	\$43.00	\$0.00	No EOB	\$43.00	Rule 133.307 <u>MFG, Medicine Ground Rule</u> (I)(A)(9)(c), (I)(A)(10)(a) & (I)(C)(3)	Review of the office note supports delivery of service. Reimbursement is recommended in the amount of \$43.00.
	99213	\$48.00	\$0.00	No EOB	\$48.00	Rule 133.307 <u>MFG, Evaluation/ Management Ground Rule</u> (VI)(B)	Review of the office note supports delivery of service. Reimbursement is recommended in the amount of \$48.00.
	97250	\$43.00	\$0.00	No EOB	\$43.00	Rule 133.307 <u>MFG, Medicine Ground Rule</u> (I)(A)(9)(c), (I)(A)(10)(a) & (I)(C)(3)	Review of the office note supports delivery of service. Reimbursement is recommended in the amount of \$48.00.
	97122	\$35.00	\$0.00	No EOB	\$35.00	Rule 133.307 <u>MFG, Medicine Ground Rule</u> (I)(A)(9)(b) & (I)(A)(10)(a)	Review of the office note supports delivery of service. Reimbursement is recommended in the amount of \$35.00
3/5/03	97750-MT	\$86.00	\$0.00	F	\$43.00	<u>MFG, Medicine Ground Rule</u> (I)(C)(1)(b)	Review of the "F.O.C.U.S. Custom Report", dated 3/5/03 supports delivery of service. The requestor is therefore entitled to reimbursement in the amount of \$43.00.
3/19/03	99213	\$48.00	\$0.00	R	\$48.00	<u>MFG, Evaluation/ Management Ground Rule</u> (VI)(B)	Review of the Commission's records revealed that a TWCC 21 was not filed disputing extent or compensability. Therefore the disputed charge will be reviewed according to the <u>Medical Fee Guideline</u> . Review of the office note supports delivery of service. Reimbursement is recommended in the amount of \$48.00
4/2/03	99214	\$71.00	\$0.00	N	\$71.00	<u>MFG, Evaluation/ Management Ground Rule</u> (VI)(B)	Review of the office note meets the documentation criteria set forth by the <u>MFG</u> . Reimbursement is recommended in the amount of \$71.00.

TOTAL		\$3,020.00	\$0.00		\$2,715.00		The requestor is entitled to reimbursement in the amount of \$1,320.00.
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This Amended Decision is hereby issued this 5th day of April 2004.

Margaret Q. Ojeda
 Medical Dispute Resolution Officer
 Medical Review Division

MQO/mqo

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 Amended Decision is applicable for dates of service 1/27/03 through 4/7/03 in this dispute.

This Amended Order is hereby issued this 5th day of April 2004.

Roy Lewis, Supervisor
 Medical Dispute Resolution
 Medical Review Division

RL/mqo

Enclosure: IRO Decision

REVISED 9/9/03

August 27, 2003

IRO Certificate# 5259

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

___ slipped on ice while at work on ____. MRI was performed and showed moderate joint effusion, marked chondromalacia patella. Paresthesia and pain were also noted as subjective complaints. Arthroscopic was performed 4/8/03 and patient underwent post-op rehab.

REQUESTED SERVICE (S)

1/28/03 cpt codes 97265 and 97110; 1/30/03 through 2/11/03; 2/3/03 cpt codes 95999-wp and 97265; treatment for dates of service 2/13/03 through 4/7/03

DECISION

Approve as medically necessary and appropriate.

RATIONALE/BASIS FOR DECISION

Based on the information provided, the treatment and rehab are medically necessary. Treating doctors had a sound rehab program to give the patient every opportunity to avoid surgery. When surgery became an option on 3/7/03, ___ requested therapy and rehab be continued until surgery was performed. These treating doctors were making objective decisions based on this individuals needs. From the notes provided, ___ performed therapy and monitored the rehab and therefore should be reimbursed as such. All therapies and treatments in this case are sound and medically necessary for recovery of this type of injury.