

Amended MDR Tracking Number: M5-04-2369-01 (**Previously M5-03-3252-01**)

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 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 8-12-03.

This AMENDED FINDINGS AND DECISION supersedes M5-03-3252-01 rendered in this Medical Payment Dispute involving the above requestor and respondent.

The Medical Review Division's Decision of 2-13-04 was appealed and subsequently withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of 3-22-04. An Order was rendered in favor of the Requestor. The Requestor appealed the Order to an Administrative Hearing because "As the requestor, we did not prevail on majority of the medical necessity issues, therefore, we would like dispute any dates of service that remain unpaid."

The IRO reviewed electrical stimulation, myofascial release, therapeutic procedure rendered on 10/7/02 through 11/1/02 denied based upon "V".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(r)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO concluded that electric stimulation, myofascial release and therapeutic exercises rendered from 10/7/02 through 10/21/02 were medically necessary. The IRO concluded that electric stimulation, myofascial release and therapeutic exercises rendered from 10/22/02 through 11/1/02 were not medically necessary.

On this basis, the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 10-31-03, 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:
 No EOB: Neither party in the dispute submitted EOBs for some of the disputed services. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline*.

Review of the position statement submitted by Mega Rehab, dated 11/13/02 partially states, "...Mega Rehab is not contracted through any workers' compensation commission providers..." The disputed services will be reviewed in accordance with the *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
10-2-02	97110 (3)	\$105.00	\$0.00	C	\$35.00 / 15 min	Medicine GR (I)(A)(9)(b) (I)(A)(10)(a) (I)(A)(11)(a)	See Rationale Below.
10-3-02	97110 (2)	\$70.00					
10-14-02	97113 (4)	\$240.00					
10-16-02 10-18-02					\$52.00 / 15 min		
10-2-02	97250	\$43.00	\$0.00	C	\$43.00	CPT Code Descriptor	MAR reimbursement of \$43.00 is recommended.
10-2-02	97014	\$15.00	\$0.00	C	\$15.00		MAR reimbursement of \$15.00 is recommended.
10-21-02	97110 (3)	\$105.00	\$0.00	No EOB	\$35.00 / 15 min	Medicine GR (I)(A)(9)(b) (I)(A)(10)(a) (I)(A)(11)(a)	See Rationale Below.
10-21-02	99213	\$60.00	\$0.00	No EOB	\$48.00	CPT Code Descriptor	MAR reimbursement of \$48.00 is recommended.
TOTAL							The requestor is entitled to reimbursement of \$106.00 .

Rationale for 97110 and 97113:

Recent review of disputes involving one-on-one CPT code 97110 and 97113 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 therapy notes for these dates of service do not support any clinical (mental or physical) reason as to why the patient could not have performed these exercises in a group setting, with supervision, as opposed to one-to-one therapy. The Requestor has failed to submit documentation to support reimbursement in accordance with the 1996 MFG and 133.307(g)(3). Therefore, reimbursement is 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 \$106.00 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 Decision is applicable for dates of service 10-2-02 through 11-1-02 in this dispute.

The above Amended Findings and Decision are hereby issued this 4th day of October 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

October 20, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-3252-01
New MDR Tracking #: M5-04-2369-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ 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 48 year-old female who sustained a work related injury on _____. The patient reported that while at work she sustained an injury to her neck, upper back and bilateral shoulders when she attempted to lift and pull covers of a king size bed. The patient underwent a left shoulder arthroscopy and is presently diagnosed with bilateral upper trapezius myofascitis. Postoperatively the patient was treated with physical therapy. The patient reported that during the postoperative physical therapy she sustained a re-injury to the right shoulder. The patient transferred her care to another facility where physical therapy consisting of electrical stimulation, myofascial releases and therapeutic procedures was restarted.

Requested Services

Electrical stimulation, myofascial release and therapeutic procedure from 10/7/02 through 11/1/02.

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 ____ physician reviewer noted that this case concerns a patient with bilateral shoulder pain who status post left shoulder surgery. The ____ physician reviewer also noted that the patient re-injured her right shoulder during physical therapy and started physical therapy at a different facility. The ____ physician reviewer indicated that from 10/7/02 through 10/21/02 the patient showed good improvement in the right shoulder demonstrated by increased range of motion and was within normal limits by 10/21/02. However, the ____ physician reviewer explained that the patient continued to complain of pain in her left shoulder with a decline of range of motion. The ____ physician reviewer noted that the patient showed improvement with right shoulder motor strength to within normal limits by 10/21/02 but had continued decreased strength in her left shoulder. The ____ physician reviewer explained that the patient responded well to treatment from 10/7/02 through 10/21/02 in the right shoulder. However, the ____ physician reviewer also explained that the range of motion in the left shoulder had declined and there was no real change in pain or motor strength during treatment from 10/7/02 through 10/21/02. The ____ physician reviewer further explained that the documentation provided did not demonstrated objective measurement in left shoulder range of motion/motor strength/pain as of 11/1/02. Therefore, the ____ physician consultant concluded that the electrical stimulation, myofascial release and therapeutic procedure from 10/7/02 through 10/21/02 were medically necessary to treat this patient's condition. However, the ____ physician consultant also concluded that the electrical stimulation, myofascial release and therapeutic procedure from 10/22/02 through 11/1/02 were not medically necessary to treat this patient's condition.

Sincerely,