

MDR Tracking Number: M5-04-2453-01

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 January 23, 2004.

Based on correspondence from the requestor, Atlantis Healthcare Clinic, L.P., dated 05-18-04, CPT code 99213 for dates of service 06-17-03 and 07-08-03 have been withdrawn. Also, dates of service from 07-15-03 through 07-31-03 have been withdrawn from the requestor's dispute and will not be addressed in the review.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the 97032-electrical stimulation, 97110-therapeutic exercises, 97250-myofascial release, 97265-joint mobilization, 99213-office visits with manipulation, 95851-ROM measure, 97010-hot/cold pack therapy, and 97750-MT-functional capacity evaluation-muscle testing from 05-06-03 through 06-06-03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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

On 07-26-04, 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
05-22-03	99080-73	\$15.00	\$0.00	V	\$15.00	1996 MFG	The TWCC73 is a required report and is not subject to an IRO review. Therefore, recommend reimbursement in the amount of \$15.00.
06-09-03	97035 97110 97250 97265 97750-MT 99213-MP	\$48.00 \$111.00 \$46.00 \$46.00 \$46.00 \$51.00	\$0.00	NO EOB	\$22.00 x2=44.00 \$35.00 x3=105 \$43.00 \$43.00 \$43.00 \$48.00	1996 MFG	Neither the requestor or the respondent submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services except 97110 will be reviewed according to the 1996 MFG. Recommend reimbursement of \$221.00. SEE RATIONALE BELOW TABLE FOR CPT CODE 97110
06-10-03	97032 97110 97250 97265 99213-MP	\$48.00 \$111.00 \$46.00 \$46.00 \$51.00	\$0.00	NO EOB	\$22.00 x2=44.00 \$35.00 x3=105 \$43.00 \$43.00 \$48.00	1996 MFG	Neither the requestor or the respondent submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services except 97110 will be reviewed according to the 1996 MFG. Recommend reimbursement of \$178.00. SEE RATIONALE BELOW TABLE FOR CPT CODE 97110
06-11-03	97032 97110 97250 97265 99213-	\$48.00 \$111.00 \$46.00 \$46.00 \$51.00	\$0.00	NO EOB	\$22.00 x2=\$44.00 \$35.00 x3=\$105.00 \$43.00 \$43.00 \$48.00	1996 MFG	Neither the requestor or the respondent submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services except

	MP						97110 will be reviewed according to the 1996 MFG. Recommend reimbursement of \$178.00. SEE RATIONALE BELOW TABLE FOR CPT CODE 97110
06-13-03	97032 97110 97250 97265 99213- MP	\$48.00 \$111.00 \$46.00 \$46.00 \$51.00	\$0.00	NO EOB	\$22.00 x2=\$44.00 \$35.00 x3=\$105.00 \$43.00 \$43.00 \$48.00	1996 MFG	Neither the requestor or the respondent submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services except 97110 will be reviewed according to the 1996 MFG. Recommend reimbursement of \$178.00. SEE RATIONALE BELOW TABLE FOR CPT CODE 97110
06-16-03	97032 97110 97250 97265 99213- MP	\$48.00 \$111.00 \$46.00 \$46.00 \$51.00	\$0.00	NO EOB	\$22.00 x2=\$44.00 \$35.00 x3=\$105.00 \$43.00 \$43.00 \$48.00	1996 MFG	Neither the requestor or the respondent submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services except 97110 will be reviewed according to the 1996 MFG. Recommend reimbursement of \$178.00. SEE RATIONALE BELOW TABLE FOR CPT CODE 97110
06-17-03	97250 97265	\$46.00 \$46.00	\$0.00	NO EOB	\$43.00 \$43.00	1996 MFG	Neither the requestor or the respondent submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 MFG. Recommend reimbursement of \$86.00.
06-19-03	97250 97265 99213- MP	\$46.00 \$46.00 \$51.00	\$0.00	NO EOB	\$43.00 \$43.00 \$48.00	1996 MFG	Neither the requestor or the respondent submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services except 97110 will be reviewed according to the 1996 MFG. Recommend reimbursement of \$134.00.
06-23-03	99080-73	\$15.00	\$0.00	NO EOB	\$15.00	1996 MFG	Neither the requestor or the respondent submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service will be reviewed according to the 1996 MFG. Recommend reimbursement of \$15.00.
06-24-03	97250 97265 99213- MP	\$46.00 \$46.00 \$51.00	\$0.00	NO EOB	\$43.00 \$43.00 \$48.00	1996 MFG	Neither the requestor or the respondent submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed will be reviewed according to the 1996 MFG. Recommend reimbursement of \$134.00.
06-26-03	97250 97265 99213- MP	\$46.00 \$46.00 \$51.00	\$0.00	NO EOB	\$43.00 \$43.00 \$48.00	1996 MFG	Neither the requestor or the respondent submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 MFG. Recommend reimbursement of \$134.00.
07-01-03	97250 97265 99213- MP	\$46.00 \$46.00 \$51.00	\$0.00	NO EOB	\$43.00 \$43.00 \$48.00	1996 MFG	Neither the requestor or the respondent submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 MFG. Recommend reimbursement of \$134.00.

07-08-03	97250 97265	\$46.00 \$46.00	\$0.00	NO EOB	\$43.00 \$43.00 \$48.00	1996 MFG	Neither the requestor or the respondent submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 MFG. Recommend reimbursement of \$134.00.
TOTAL							The requestor is entitled to reimbursement of \$1719.00

Rationale for CPT code 97110- 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 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 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 05-22-03 through 07-08-03 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 8th day of October 2004.

Patricia Rodriguez
 Medical Dispute Resolution Officer
 Medical Review Division
 PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

June 21, 2004

Amended letter 10/01/2004

Rosalinda Lopez
 Program Administrator
 Medical Review Division
 Texas Workers Compensation Commission
 7551 Metro Center Drive, Suite 100, MS 48
 Austin, TX 78744-1609

RE: Injured Worker:
 MDR Tracking #: M5-04-2453-01
 IRO Certificate #: IRO4236

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ___ when while working as a food worker, she pulled a box of chicken out of the freezer, lost her balance and fell landing on her tailbone, hip, and back. She was taken and treated at the emergency department for a non-displaced coccyx fracture, lumbar disc displacement without myelopathy, lumbosacral sprain, and a contusion of the hip. A portion of the patient's treatment was provided by a chiropractor which included; 97032-Electrical stimulation, 97110-Therapeutic exercises, 97250-Myofascial release, 97265-Joint mobilization, 99213-Office visits with manipulation, 95851-ROM measure, 97010-Hot/Cold pack therapy, and 97750-MT Functional capacity evaluation-muscle testing.

Requested Service(s)

97032-Electrical stimulation, 97110-Therapeutic exercises, 97250-Myofascial release, 97265-Joint mobilization, 99213-Office visits with manipulation, 95851-ROM measure, 97010-Hot/Cold pack therapy, and 97750-MT-Functional capacity evaluation-muscle testing billed from 05/06/03 through 06/06/03.

Decision

It is determined that the 97032-Electrical stimulation, 97110-Therapeutic exercises, 97250-Myofascial release, 97265-Joint mobilization, 99213-Office visits from manipulation, 95851-ROM measure, 97010-Hot/Cold pack therapy, and 97750-MT Functional capacity evaluation-muscle testing billed from 05/06/03 through 06/06/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following an injury. However, in order -for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type, and duration of services must be reasonable and consistent with the standards of the health care community. Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. In this case, there is no documentation of objective or functional improvement in this patient's condition and there is no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment.

There is no documentation or supporting evidence to demonstrate any significant continuing benefit. The daily progress notes were computer generated, essentially verbatim from day to day and practically super imposable upon each other. Therefore, there is no documentation to support the medical necessity for the treatment in question.

According to the Medicare Guidelines, if a patient's expected restoration potential is insignificant in relation to the extent and duration of the physical medicine services required to achieve such potential, the services are not considered reasonable or necessary. In this case, the medical records indicate that the patient obtained no relief from the treatments (pain rating of 5 on 05/06/03 when the care in question was begun and a pain

rating of 5 on 06/06/03), promotion of recovery was not accomplished, and there was no enhancement of the employee's ability to return to or retain employment. Therefore, the treatment in question was not medically necessary.

Sincerely,