

MDR Tracking Number: M5-04-2616-01

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 April 20, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the issues of medical necessity. The office visits with manipulation from 04-25-03 through 05-28-03, electrical stimulations, ultrasound from 04-25-03 through 04-30-03 and two units of therapeutic exercises per encounter that were denied with V from 04-25-03 through 05-28-03 **were** medically necessary. The neuromuscular re-education from 04-25-03 through 05-28-03, and myofascial release, electrical stimulation, and therapeutic exercises in excess of the approved, **were not** medically necessary. 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.

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

On 07-02-04, 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
04-21-03	99213-MP	\$50.00	\$0.00	No EOB	\$48.00	1996 Medical Fee Guideline	Neither the requestor nor the respondents submitted EOB's for services rendered 04-21-03. The services rendered on 04-21-03 will be reviewed in accordance with the 1996 MFG. Reimbursement is recommended in the amount of \$136.00.
	97035	\$25.00			\$22.00		
	97265	\$45.00			\$43.00		
	97032	\$25.00			\$22.00		
	97110x2	\$90.00			\$35.00 x2		

							See rationale below for CPT code 97110.
04-23-03	99213- MP 97035 97265 97032 97110x2	\$50.00 \$25.00 \$45.00 \$25.00 \$90.00	\$0.00	No EOB	\$48.00 \$22.00 \$43.00 \$22.00 \$35.00x2	1996 Medical Fee Guideline	Neither the requestor nor the respondents submitted EOB's for services rendered 04-23-03. The services rendered on 04-23-03 will be reviewed in accordance with the 1996 MFG. Reimbursement is recommended in the amount of \$136.00. See rationale below for CPT code 97110.
04-25-03 04-28-03 04-30-03 05-02-03	97110x3 97110x3 97110x3 97110x3	\$135.00 \$135.00 \$135.00 \$135.00	\$0.00	D	\$35.00x3 \$35.00x3 \$35.00x3 \$35.00x3	1996 Medical Fee Guideline	See Rationale below for CPT code 97110.
TOTAL		\$1010.00					The requestor is entitled to reimbursement of \$272.00.

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 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 04-21-03 through 05-28-03 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 5th day of November 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:
MDR Tracking Number: M5-04-2616-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

June 8, 2004

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 Texas Medical Foundation, 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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

CLINICAL HISTORY

Patient is a 35-year-old male who, on ____, was working for ____ as a floor hand when he pivoted on his right knee and had immediate onset of pain. He was seen initially by Dr. P, an orthopedic surgeon who performed the first surgery on 12/12/02. ____ then changed treating doctors in January of 2003 to Dr. T, a doctor of chiropractic, who began conservative care. When response was less than optimal, he was referred to another orthopedist, Dr. C, who performed a second surgery on 04/03/03. On 04/14/03, the patient returned to Dr. C who released him to begin post-operative therapy with Dr. T.

REQUESTED SERVICE(S)

Office visits, with manipulation (99213-MP), neuromuscular reeducation (97112), ultrasound (97035), joint mobilization (97265), therapeutic exercises (97110), and electrical stimulation, attended (97032) for dates of service 04/25/03 through 05/28/03.

DECISION

The office visits with manipulation (99213-MP) are approved for all dates within the range. The attended electrical stimulations (97032) and ultrasounds (97035) are also approved, but only through date of service 04/30/03. Only two (2) units of therapeutic exercise (97110) are approved per encounter within the specified date range.

All remaining services and procedures are denied.

RATIONALE/BASIS FOR DECISION

Since joint mobilization (97265) is a component of spinal manipulation, and manipulation was performed on each encounter, this service is duplicative. As such, the medical

necessity of joint mobilization cannot be supported. Furthermore, there is nothing in either the diagnosis or documentation submitted that supports the medical necessity for the performance of the neuromuscular reeducation (97112) procedure.

Attended electrical stimulation (97032) and ultrasound (97035) are passive modalities, and as such, would be appropriate post-surgically until 04/30/03. Thereafter, the patient could have been transitioned into an active program of rehabilitation and exercise with decreased dependence on the passive care. In addition, the diagnosis in this case – a post-surgical right knee – only supports the medical necessity for 2 units of therapeutic exercise per patient encounter.