

MDR Tracking Number: M5-04-2675-01

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 4-26-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of 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 \$460** 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.

The one additional unit of therapeutic procedure on 4-21-03, 4-25-03, 5-9-03, 5-28-03, 6-4-03 and 6-9-03 and the office visits on 6-20-03 and 6-27-03 were **found** to be medically necessary. The one additional unit of therapeutic procedure on 5-21-03 **was not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

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. On 10-20-04 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.

CPT Code 99213 for dates of service 4-21-03, 4-23-03, 4-25-03, 5-9-03, 5-13-03, 5-14-03, 5-16-03, 5-19-03, 5-21-03, 5-23-03, 5-27-03, 5-28-03, 5-30-03, 6-2-03, 6-4-03, 6-9-03, 6-30-03, 7-2-03, 7-7-03, 7-9-03 and 7-14-03 was denied with F or there was no code present on the EOB. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. **Therefore, reimbursement is recommended in the amount of \$1008.00. (\$48.00 x 21).**

CPT Code 99213 for dates of service 4-25-03 and 4-28-03 were denied with G. According to Rule 133.304 (c) the carrier must specify which service this code was global to, therefore it will be reviewed according to the 96 MFG. **Reimbursement is recommended in the amount of \$96.00.**

CPT Code 97250 for dates of service 4-21-03, 4-23-03, 4-25-03, 4-28-03, 5-9-03, 5-13-03, 5-14-03, 5-16-03, 5-19-03, 5-21-03, 5-23-03, 5-27-03, 5-28-03, 5-30-03, 6-2-03, 6-4-03, 6-9-03, 6-20-03, 6-27-03, 6-30-03, 7-2-03., 7-7-03, 7-9-03 and 7-14-03 was denied with F or there was no code present on the EOB. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. **Reimbursement is recommended in the amount of \$1,032.00. (\$43.00 x 24)**

CPT Code 97265 for dates of service 4-21-03, 4-23-03, 4-25-03, 4-28-03, 5-9-03, 5-13-03, 5-14-03, 5-16-03, 5-19-03, 5-21-03, 5-23-03, 5-27-03, 5-28-03, 5-30-03, 6-2-03, 6-4-03, 6-9-03, 6-20-03, 6-27-03, 6-30-03, 7-2-03, 7-7-03, 7-9-03 and 7-14-03 was denied with F or there was no code present on the EOB. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. **Reimbursement is recommended in the amount of \$1,032.00. (\$43.00 x 24)**

CPT Code 97150 for dates of service 4-21-03, 4-23-03, 4-25-03, 4-28-03, 5-9-03, 5-13-03, 5-14-03, 5-16-03, 5-19-03, 5-21-03, 5-23-03, 5-27-03, 5-28-03, 5-30-03, 6-2-03, 6-4-03, 6-9-03, 6-20-03, 6-27-03, 6-30-03, 7-2-03, 7-7-03, 7-9-03 and 7-14-03 was denied with F or there was no code present on the EOB. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. **Reimbursement is recommended in the amount of \$648.00. (\$27.00 x 24)**

Regarding CPT Code 97110: One additional unit of therapeutic procedure on 4-21-03, 4-25-03, 5-9-03, 5-28-03, 6-4-03 and 6-9-03 was declared medically necessary as discussed above. 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.**

There was no code given on the EOB's for 5 units of CPT Code 97750-MT for date of service 6-20-03. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. **Reimbursement is recommended in the amount of \$215.00.**

This Finding and Decision is hereby issued this 17th day of November, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 to dates of service 4-21-03 through 6-27-03 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 Decision and Order is hereby issued this 17th day of November, 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

July 30, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2675-01
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 female who sustained a work related injury on ----- . The patient reported that while at work she fell from a step ladder and injured both her knees and lower back. On 11/1/02 the patient underwent an MRI of both knees. Initially the patient had been treated with physical therapy modalities. The patient was referred to an orthopedic surgeon and on 7/22/03 the patient underwent right knee surgery. Postoperatively the patient was treated with aquatic therapy progressing to a strengthening and stability phase of therapy.

Requested Services

Office visit for DOS 6/20/03 and 6/27/03, therapeutic procedures (1 unit) for 4/21/03, 4/25/03, 5/9/03, 5/21/03, 5/28/03, 6/4/03, and 6/9/03.

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

Documents Submitted by Requestor:

1. Subsequent Narrative Report 11/6/03, 9/26/03
2. Office notes 3/14/03 – 1/2/04
3. MRI report 11/1/02
4. Therapeutic procedures office notes from 3/24/03 - 12/15/03

Documents Submitted by Respondent:

1. No medical documents submitted

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 female who sustained a work related injury to her bilateral knees and lower back on ----- . The ----- chiropractor reviewer also noted that the initial treatment for the patient included physical therapy modalities and that the patient subsequently underwent right knee surgery. The ----- chiropractor reviewer indicated that the patient had been treated with therapeutic procedures from 4/21/03 through 6/9/03. The ----- chiropractor reviewer explained that the patient was not a candidate for epidural steroid injections and that the therapeutic procedures were medically necessary from 4/21/03 through 6/9/03. The ----- chiropractor reviewer also explained that conservative care becomes more medically necessary when there are known contraindications to other types of procedures or treatments. The ----- chiropractor reviewer indicated that a conservative approach in treatment should be given ample opportunity to benefit. However, the ----- chiropractor reviewer explained that on 5/21/03 8 units of time were billed when the patient was treated for 7 units of time. The ----- chiropractor reviewer also explained that the patient benefited subjectively and objectively from the treatment provided. Therefore, the ----- chiropractor consultant concluded that the one additional unit of therapeutic procedure on 5/21/03 was not medically necessary to treat this patient's condition. However, the ----- chiropractor consultant further concluded that one additional unit of therapeutic procedure on 4/21/03, 4/25/03, 5/9/03, 5/28/03, 6/4/03, and 6/9/03, and that the office visits on 6/20/03 and 6/27/03 were medically necessary to treat this patient's condition.

Sincerely,
