

MDR Tracking Number: M5-04-3138-01

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 05-19-04.

The IRO reviewed therapeutic exercises, ultrasound, physical therapy re-evaluation and office visits rendered from 07-23-03 through 09-11-03 that were denied based upon "U".

The IRO determined that the treatment and services in dispute from 07-23-03 through 07-28-03 **were** medically necessary. The IRO determined that treatment and services beyond 07-30-03 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. 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.

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 07-06-04, 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.

CPT code 97110 dates of service 05-23-03 through 08-01-03 (15 DOS) denied with denial code "D" (duplicate). 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 of 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. Reimbursement not recommended.

CPT code 97260 dates of service 05-23-03, 06-23-03 and 07-25-03 denied with denial code "D" (duplicate). Per Rule 133.304(c) the carrier did not specify which service 97260 was a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$105.00 (\$35.00 X 3 DOS).

CPT code 97035 dates of service 05-23-03, 05-27-03, 05-30-03, 06-12-03, 06-16-03, 06-18-03, 06-23-03, 07-17-03, 07-21-03, 07-25-03, 07-28-03, 07-30-03 and 08-01-03 denied with denial code "D" (duplicate). Per Rule 133.304(c) the carrier did not specify which service 97035 was a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended for dates of service 05-23-03 through 07-30-03 (12 DOS) in the amount of \$264.00. Reimbursement for date of service 08-01-03 is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$14.21 (\$11.37 X 125%).

CPT code 99213 dates of service 05-30-03, 06-23-03 and 07-17-03 denied with denial code "D" (duplicate). Per Rule 133.304(c) the carrier did not specify which service 99213 was a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$144.00 (\$48.00 X 3 DOS).

CPT code 97265 date of service 06-20-03 denied with denial code "D" (duplicate). Per Rule 133.304(c) the carrier did not specify which service 97265 was a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$43.00.

CPT code 99070 date of service 06-23-03 denied with denial code "D" (duplicate). Per Rule 133.304(c) the carrier did not specify which service 99070 was a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$18.00.

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) and in accordance with the Medicare program methodologies effective August 1, 2003 per Commission Rule 134.202(c), 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 05-23-03 through 08-01-03 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 Findings and Decision and Order are hereby issued this 24th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh
Enclosure: IRO Decision

July 27, 2004
October 26, 2004
January 11, 2005
January 20, 2005

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Corrected date of service in "Decision"

Re: Medical Dispute Resolution
MDR #: M5-04-3138-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating

physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: correspondence, physical therapy notes and radiology report.

Clinical History:

This female claimant injured her right shoulder in a work-related accident on ____.

Disputed Services:

Therapeutic exercises, ultrasound, physical therapy re-evaluation and office visits from 07/23/03 through 09/11/03.

Decision:

The reviewer partially agrees with the insurance carrier. The treatment and services in dispute as stated above from 07/23/03 through 07/28/03 were medically necessary. The treatment and services in dispute as stated above beyond 07/30/03 were not medically necessary in this case.

Rationale:

Given the diagnosis, treatment, history of injury, and the date of injury, the treatment given appears to be within reasonable and necessary limits up through the date of 07/30/03. The MRI results revealing a rotator cuff of the supraspinatus testing tendon tear were given to the doctor, and the doctor had gone over the results with the patient. The tear appeared to be a full-thickness or near complete partial tear measuring 5-8 mm in size. With this type of tear, it is very difficult to rehab successfully under a moderate time frame. The patient had adequate preconditioning with therapy prior to the findings of the MRI.

After that date, after the revelation of the MRI, treatment should have been suspended and referral should have been made to an orthopedic surgeon for a second opinion for possible surgical intervention. It appeared that the orthopedic surgeon reviewed the MRI and made notes on 07/06/03, from his office visit one year later, regarding surgical possibilities and surgical counseling. The reviewer feels that these should have probably been taken care of one year earlier when the result of the MRI was given due to the size of the tear, and the location.

Therefore, the treatment of the therapeutic exercises, ultrasound, physical therapy, reevaluation, and office visits after 07/30 would not be relevant until after surgery. Once

the surgery was completed, then physical therapy could be reassessed with a post-surgical rehab progressing to phase 1, phase 2, stretching, conditioning, flexibility exercises and then graduated to active rehab and possible work-conditioning or work-hardening.

Sincerely,

Gilbert Prud'homme
Secretary & General Counsel
GP:thh