

MDR Tracking Number: M5-04-3288-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 5-28-04.

The Medical Review 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 office visits, therapeutic exercises, joint mobilization, manual traction, myofascial release, medical conference and manual therapy from 7-14-03 through 12-5-03 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute 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 7-15-04, 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 carrier denied CPT Code 99213 for dates of service 11-10-03, 11-11-03, 11-12-03, 11-18-03, 11-19-03, 12-1-03, 12-3-03 and 12-5-03 with an F or an N. According to 133.307(g)(3)(a-f): No additional documentation was submitted by the requester supporting the documentation criteria set forth by this CPT Code descriptor. **No reimbursement recommended.**
- The carrier denied one or more units of CPT Code 97110 for dates of service 11-10-03, 11-11-04, 11-12-03, 11-19-04, 12-1-03 with an F. 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.**
- Regarding CPT Code 99214 for date of service 11-25-03: This service was billed by the requestor and denied by the carrier. Neither the requestor nor the respondents submitted EOB's and did not timely respond to the request for additional information. These dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide

a valid basis for the denial of this service, **reimbursement is recommended in the amount of \$98.10.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees for date of service 11-25-03 as outlined above:

- in accordance with Medicare program reimbursement methodologies for dates of service after 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.

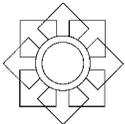
The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 21st day of October, 2004.

Donna Auby

Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO Decision



## Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

August 18, 2004

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 #: M5-04-3288-02  
IRO Certificate #: IRO4326

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 care. 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 female patient suffered a right wrist repetitive motion injury on \_\_\_\_ and post right de Quervain's release on 07/17/02 and right carpal tunnel release on 10/21/03. She continues with complaints of pain to the right wrist and shoulder.

#### Requested Service(s)

Office visits, therapeutic exercises, joint mobilization, manual traction, myofascial release, medical conference, and manual therapy for dates of service 07/14/03 through 12/05/03.

#### Decision

It is determined that office visits, therapeutic exercises, joint mobilization, manual traction, myofascial release, medical conference, and manual therapy were not medically necessary to treat this patient's medical condition from 07/14/03 through 12/05/03.

#### Rationale/Basis for Decision

The medical records provided lacked any documentation such as re-evaluation reports showing functional improvement and/or benefit from past care that would support the medical necessity of the treatment in dispute. Therefore, it is determined that office visits, therapeutic exercises, joint mobilization, manual traction, myofascial release, medical conference, and manual therapy were not medically necessary to treat this patient's medical condition from 07/14/03 through 12/05/03.

Sincerely,



Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:vn

Attachment

**Information Submitted to TMF for TWCC Review**

**Patient Name:** \_\_\_\_

**TWCC ID #: M5-04-3288-02**

**Information Submitted by Requestor:**

- Chiropractic/Rehabilitation notes 07/14/03-11/12/03
- Office notes/Dr \_\_\_\_ 05/07/02, 05/06/03, 06/16/03
- Office noted/Dr Kay 01/09/03
- Office notes/Dr Oishi 09/30/03
- Operative reports 07/17/02, 10/21/03
- Comparative Muscle/ROM Test 11/05/03
- Radiology reports 04/12/02
- MRI report 02/13/03
- EMG report 10/28/02

**Information Submitted by Respondent:**