

THIS DECISION HAS BEEN APPEALED. THE
 FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
 SOAH DOCKET NO. 453-05-1228.M5

MDR Tracking Number: M5-04-3509-01

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 06-14-04. Date of service 06-13-03 was not timely filed per Rule 133.308(e)(1) therefore this date of service will not be reviewed by the Medical Review Division.

The IRO reviewed office visits, mechanical traction, electrical stimulation, massage, therapeutic exercises, chiropractic manipulation, therapeutic procedure, diathermy, supplies and muscle testing rendered from 08-25-03 through 10-29-03 that were denied based "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the 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 07-19-04, 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	MAR\$	Reference	Rationale
06-16-03	99070	\$25.00 (1 unit)	\$0.00	F	DOP		Reimbursement in the amount of \$25.00 recommended.
07-17-03	95851	\$200.00 (1 unit @ \$40.00 X 5 units)	\$0.00	NO EOB	\$36.00	Rule 133.307(e)(2)(B)	The requestor provided convincing evidence of carrier receipt of the provider request for an EOB. Relevant medical documentation submitted supports delivery of service as billed. Reimbursement recommended in the amount

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
							of \$180.00 (\$36.00 X 5 units)

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR \$	Reference	Rationale
08-15-03	99070	\$25.00 (1 unit)	\$9.60	F	DOP		Additional reimbursement in the amount of \$15.40 recommended.
10-07-03	95851	\$153.00 (1 unit @ \$30.60 X 5 units)	\$0.00	F,435	\$30.61		Service denied as included in value of the comprehensive procedure. According to Medicare's National Correct coding Initiative (NCCI) code 95851 is a component of code 99213 billed on the same date of service. Code 95851 will not be paid separately. No reimbursement recommended.
11-03-03	99211-25	\$23.35 (1 unit)	\$0.00	NO EOB	\$23.36	Rule 133.307(e)(2)(B)	The requestor provided convincing evidence of carrier receipt of the provider request for an EOB. Relevant medical documentation submitted supports delivery of services as billed. Reimbursement in the amount of \$23.35 recommended.
11-03-03	97110	\$260.00 (1 unit @ \$32.50 X 8 units)	\$0.00	NO EOB	\$32.64	Rule 133.307(e)(2)(B)	The requestor provided convincing evidence of carrier receipt of the provider request for an EOB. See rational below. No reimbursement recommended.
11-03-03	98941	\$41.88 (1 unit)	\$0.00	NO EOB	\$41.89	Rule 133.307(e)(2)(B)	The requestor provided convincing evidence of carrier receipt of the provider request for an EOB. Relevant medical documentation submitted supports delivery of

							services as billed. Reimbursement in the amount of \$41.88 recommended.
11-03-03	97150	\$21.37 (1 unit)	\$0.00	NO EOB	\$21.38	Rule 133.307 (e)(2)(B)	The requestor provided convincing evidence of carrier receipt of the provider request for an EOB. Relevant medical documentation submitted supports delivery of services as billed. Reimbursement in the amount of \$21.37 recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR \$	Reference	Rationale
11-03-03	97124	\$25.69 (1 unit)	\$0.00	NO EOB	\$25.70	Rule 133.307 (e)(2)(B)	The requestor provided convincing evidence of carrier receipt of the provider request for an EOB. Relevant medical documentation submitted supports the delivery of service as billed. Reimbursement in the amount of \$25.69 recommended.
11-03-03	98943	\$27.97	\$0.00	NO EOB	\$24.21	Rule 133.307 (e)(2)(B)	The requestor provided convincing evidence of carrier receipt of the provider request for an EOB. Relevant medical documentation submitted supports the delivery of service as billed. Reimbursement in the amount of \$24.21 recommended.
11-03-03	97750-MT	\$233.80 (1 unit @ \$33.40 X 7 units)	\$0.00	Y/973	\$33.41		Service was denied as modifier incorrect or no longer valid. The requestor did not bill with a modifier. Reimbursement in the amount of \$233.80 (\$33.40 X 7 units) recommended.
TOTAL		\$1,037.06	\$9.60				Requestor is entitled to reimbursement in the amount of \$590.70

RATIONALE: 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 (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

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 Decision is applicable for dates of service 06-16-03 through 11-03-03 in this dispute.

This Findings and Decision and Order are hereby issued this 7th day of September 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

August 25, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3509-01
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 lost her balance and sat down hard injuring her right hip, thoracic and lumbar spine and sacrum. The patient underwent x-rays of the lower spine and unilateral hip on 6/23/03 and an MRI of the shoulder and cervical spine on 7/30/03. The initial diagnoses for this patient included thoracic, lumbar sacrum and right hip sprain/strain and myofascial pain syndrome. The current diagnoses for this patient have included sprain/strain to thoracic/lumbar/cervical/sacrum/right hip and shoulder. Treatment for this patient's condition has included physical therapy consisting of therapeutic exercise, chiropractic manipulation, mechanical traction, massage, diathermy and therapeutic procedures. The patient had also been treated with oral medications.

Requested Services

Office visits, mechanical traction, electrical stimulation, massage, therapeutic exercises, chiropractic manipulation, therapeutic procedure, diathermy, supplies, and muscle testing from 8/25/03 through 10/29/03.

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

Documents Submitted by Requestor:

1. SOAP notes 6/13/03 – 11/5/03
2. Therapeutic procedure charts 6/18/03 - 11/3/03

Documents Submitted by Respondent:

1. Independent Review Summary 7/22/04
2. MRI reports 7/30/03
3. X-ray reports 6/23/03
4. SOAP 7/13/03 – 6/15/04

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her right hip, thoracic and lumbar spine and sacrum. The ----- chiropractor reviewer also noted that treatment for this patient's condition has included physical therapy

consisting of therapeutic exercise, chiropractic manipulation, mechanical traction, massage, diathermy and therapeutic procedures, and oral medications. The ----- chiropractor reviewer indicated that the patient has no positive findings on MRI. The ----- chiropractor reviewer explained that the patient underwent extensive treatment with different modalities without documented improvement. The ----- chiropractor reviewer further explained that this patient's documented symptoms do not require such extensive treatment. Therefore, the -----

chiropractor consultant concluded that the office visits, mechanical traction, electrical stimulation, massage, therapeutic exercises, chiropractic manipulation, therapeutic procedure, diathermy, supplies, and muscle testing from 8/25/03 through 10/29/03 were not medically necessary to treat this patient's condition.

Sincerely,