MDR Tracking Number: M5-04-4088-01

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. The dispute was received on 7-30-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on 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 $460.00** 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 radiologic exam, chiropractic manipulation, manual therapy technique, ultrasound, electrical stimulation, massage, therapeutic procedures, gait training, neurological reeducation and mechanical traction from 10-8-03 through 3-16-04 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues 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 9-1-04 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.

Regarding CPT Code 97110 for dates of service 1-20-04 (4 units) and 3-16-04 (2 units): 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. **Reimbursement not recommended.**

Regarding CPT code 98940 for date of service 1-20-04: Neither the requestor nor the respondent provided EOBs, however, there is "convincing evidence of the carrier's receipt of the provider request for an EOB" according to 133.307 (e)(2)(B). **Recommend reimbursement of $32.84.**

Regarding CPT code 97124 for dates of service 1-20-04 and 3-16-04: Neither the requestor nor the respondent provided EOBs, however, there is "convincing evidence of the carrier's receipt of the provider request for an EOB" according to 133.307 (e)(2)(B). **Recommend reimbursement of $56.18. ($28.09 x 2)**

Regarding CPT code 97112 for date of service 3-16-04: Neither the requestor nor the respondent provided EOBs, however, there is "convincing evidence of the carrier's receipt of the provider request for an EOB" according to 133.307 (e)(2)(B). **Recommend reimbursement of $36.69.**

This Finding and Decision is hereby issued this 15th day of December, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees 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. This Decision is applicable for dates of service 10-8-03 through 3-16-04 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 Order is hereby issued this 15th day of December 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

IRO Medical Dispute Resolution M5 Retrospective Medical Necessity
IRO Decision Notification Letter

Date: 11/18/2004
Injured Employee:
MDR #: M5-04-4088-01
TWCC #:
MCMC Certification #: 5294

Requested Services: Dates of service 10/08/2003-03/16/2004

MCMC llc (MCMC) is an Independent Review Organization (IRO) that was selected by The Texas Workers' Compensation Commission to render a recommendation regarding the medical necessity of (Insert)

Please be advised that a MCMC Chiropractic Advisor has determined that your request for M5 Retrospective Medical Necessity, Medical Dispute Resolution on 11/18/2004 concerning the medical necessity of the above requested service hereby **overturns the carrier's decision that the services are not medically necessary.** Based on:

*Table of disputed services dated 10/08/2003 through 03/16/2004
*C.L.C. Health Care Center follow up evaluation dated 10/08/2003 through 02/11/2004
*Summit Surgery Center operative procedure report dated 03/09/2004
*Texas Pain Solutions initial visit dated 12/05/2003 through 03/26/2004
*Vista Pain Management Centers follow up report dated 10/09/2003
*Vista Diagnostic x-ray lumbar spine dated 03/23/2000
*Vista Diagnostic MRI of lumbar spine dated 03/23/2000
*Vista Diagnostic x-ray of cervical spine dated 03/23/2000
*Vista Diagnostic MRI of cervical spine dated 03/23/2000

Based solely on the submitted documentation, the treatment rendered to this injured individual from 10/08/2004 through 03/16/2004 appears to be medically necessary. The injured individual presented with a chief complaint of severe neck and lower back pain following an industrial injury dated ___. The injured individual underwent cervical fusion surgery for which there is no evidence that she received any post surgical rehabilitation. She then presented to the office of Dr. A on 10/08/2003 complaining of severe neck and lower back pain at 8 out of 10 on the visual analogue scale. She underwent a course of active rehabilitation physical therapy and pain management procedures. There is evidence that by 03/10/2004 the injured individual had noted an 85% to 90% improvement in her condition. Given the presenting complaints and improvement noted as a result of the treatment rendered, there is ample evidence that the treatment rendered to this injured individual from 10/08/2003 through 03/16/2004 was medically necessary and appropriate.

The reviewing provider is a licensed Chiropractor and certifies that no known conflict of interest exists between the reviewing chiropractor and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO. The reviewing physician is on TWCC's Approved Doctor List.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5).

In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U. S. Postal Service from the office of the IRO on this 12th day of December 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee:_____