

MDR Tracking Number: M5-04-4197-01

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.

T In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the dates of service in dispute. The Commission received the medical dispute resolution request on 8/10/04, therefore the following dates of service are not timely: 8/06/03 through 8/08/03.

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** 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 IRO has determined that the therapeutic exercises, therapeutic activities, manual therapy, office visits, and neuromuscular re-education services that were denied for payment with a "U" and rendered from 8/06/03 through 4/28/04 were medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

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 September 9, 2004, 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 97140 for date of service 8/13/03 was denied by the carrier with "F", fee reduction guideline. However, no payment was made. 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 \$61.80** (2 units).

CPT code 99212 for date of service 8/14/03 was denied by the carrier with "O", denial after reconsideration. However, the initial EOB was not provided. For dates of service 3/16/04 through 4/16/04, this code was denied by the carrier with "N", not appropriately documented. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service for the above dates. **Reimbursement is recommended in the amount of \$628.65** (for 15 dates of service from 8/14/03 through 4/16/04).

CPT code 97110 for date of service 8/13/03: 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 has reviewed the matters in light all of the Commission requirements for proper documentation. The MDR 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.**

This Findings and Decision is hereby issued this 1st day of November 2004.

Regina L. Cleave
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 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 Order is applicable to dates of service 8/06/03 through 4/28/04 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 1st day of November 2004.

Hilda H. Baker, Manager
Medical Dispute Resolution
Medical Review Division

HHB/rlc

Enclosure: IRO decision

October 15, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-4197-01
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 male who sustained a work related injury on ----- . The patient reported that while at work he injured his right shoulder and low back when he was knocked to the ground by a tire. The patient reportedly sustained a tear of the rotator cuff right shoulder and a disc bulge in the lumbar spine. A MRI of the lumbar spine performed on 9/8/03 indicated a L3-4 diffuse disc bulge with a broad based 4mm left intraforaminal disc protrusion and a L4-5 diffuse disc bulge. A MRI of the right shoulder performed on 9/8/03 indicated small full thickness tear of the anterior supraspinatus tendon, and a intrasubstance partial tear of the anterior infraspinatus tendon. The patient subsequently underwent surgery to the right shoulder on 2/14/04 and was treated with postoperative therapy that consisted of active modalities, active and passive stretching, neuromuscular reeducation, joint mobilization and myofascial release. The patient had also participated in a chronic pain management program for chronic low back pain. The diagnoses for this patient have included right shoulder impingement syndrome with probable rotator cuff tear, right shoulder strain and sprain, and lumbar IVD without myelopathy.

Requested Services

Therapeutic exercises, therapeutic activities, manual therapy, ov/outpatient, and neuromuscular reeducation from 8/14/03 through 4/28/04.

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

Documents Submitted by Requestor:

1. History of Presenting Injury ____
2. Office Notes 8/6/03 – 4/28/04
3. Orthopedic Note 12/17/03, 3/3/04, 3/16/04, 6/21/04, 7/19/04
4. Operative Note 10/30/03
5. MRI reports 9/8/03

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a male who sustained a work related injury on -----. The ----- chiropractor reviewer indicated that this patient sustained two serious injuries in one incident. The ----- chiropractor reviewer noted that the patient was treated with conservative care for his low back and shoulder and was subsequently treated with injections for the low back injury and surgery to the shoulder. The ----- chiropractor reviewer explained that the treatment prior to surgery was to relieve pain and attempt to avoid surgery. The ----- chiropractor reviewer also explained that the treatment rendered did not reduce the patient's pain level and therefore he underwent epidural steroid injections. The ----- chiropractor reviewer indicated that postoperatively the patient required 6-8 weeks of rehabilitative care to restore range of motion and reduce pain. The ----- chiropractor reviewer explained that the patient's pain level decreased from a 6/10 to a 2/10 with treatment rendered. Therefore, the ----- - chiropractor consultant concluded that the therapeutic exercises, therapeutic activities, manual therapy, ov/outpatient, and neuromuscular reeducation from 8/14/03 through 4/28/04 were medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department