MDR Tracking Number: M5-05-0586-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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 10-19-04.

The IRO reviewed electrical stimulation, manual therapy techniques, therapeutic exercises, neuromuscular re-education, office visits, hot/cold packs, massage ultrasound and physical therapy re-evaluation rendered from 11-13-03 through 04-02-04 that were denied based upon "U".

The IRO determined that therapeutic exercises (97110) from 12-11-03 through 01-29-04, neuromuscular re-education (97112) from 12-11-03 through 01-29-04, office visit (99213-25) on 12-22-03, office visits (99212-25) on 01-07-04, 01-14-04, 01-22-04, 01-29-04, 02-04-04 and 03-23-04 as well as office visit (99212) on 04-02-04 **were** medically necessary. The IRO determined that all other remaining services **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 11-30-04, 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 on dates of service 11-13-03 and 11-14-03 denied with denial code "D" (duplicate). Since neither party submitted original EOBs the review will be per Rule 134.202. 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. Reimbursement not recommended.

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 Medicare program reimbursement 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 12-11-03 through 04-02-04 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 Findings and Decision and Order are hereby issued this 20th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

Specialty Independent Review Organization, Inc.

November 20, 2004

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:

MDR Tracking #: M5-05-0586-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was injured on ___ while working for . There were apparently to injuries while on the job. The first involved a hyperextension injury to the cervical spine while the second involved a lifting injury to the cervical spine and right shoulder/arm. He underwent treatment with Matthew Higgs, DC, injections with David Hagstrom, MD, surgical intervention for a right shoulder subacromial decompression with supraspinatus repair and clay shoveler's fracture at T1 with Dr. Scioli, and physical therapy following the surgical procedure. A work hardening program was requested and approved according to the notes; however, no specific documentation of this program was included.

Records were requested from the requestor, respondent and treating doctor. Records were received from the requestor/treating doctor, Matthew Higgs, DC. However, despite multiple attempts at retrieving records from the respondent, no records were received. Records from the requestor include the following: 9/10/04 operative report, approval for work hardening of 5/27/04 by TX Mutual, 3/30/04 letter by Dr. Higgs, FCE of 3/25/04, 3/29/04 initial behavioral health screening, Initial PT eval of 2/17/04, SOAP notes by Dena Brunk, MPT from 12/11/03 through 4/2/04, 9/9/03 post op note by Mark Scholl, MD, non physician office visits from 8/20 through 8/27/03, notes by Mark Scioli, MD from 2/20/03 through 7/15/04, standing order by Dr. Scioli of 8/13/03, operative report of 8/13/03, letter of med necessity for ambien by Dr. Scioli, apparent initial intake paperwork, injection notes by Hemmo Bosscher, MD, SOAP notes by Hemmo Bosscher, MD from 10/17/02 through 9/30/03, 5/27/04 letter from Dr. Higgs documenting peer review conversation, MRI report of 4/18/03 and 4/18/03 radiology exam report.

DISPUTED SERVICES

Disputed services include the following: electrical stimulation, manual therapy techniques (97140, 97140-59), therapeutic exercises, neuromuscular re-education, office visits (99212, 99212-25, 99213, 99213-25), hot/cold packs, massage (97124-59), ultrasound and physical therapy re-evaluation services from 11/13/03 through 4/2/04.

DECISION

The reviewer disagrees with the previous adverse determination regarding the following specific services on the following specific dates: **97110** from 12/11/03 through 1/29/04, **97112** from 12/11/03 through 1/29/04, **99213-25** (12/22/03), **99212-25** (1/7/04, 01/14/04, 1/22/04, 1/29/04, 2/4/04, 3/23/04) and **99212** (4/2/04).

The reviewer agrees with the previous adverse determination regarding all remaining services.

BASIS FOR THE /DECISION/

According to the records the surgery was performed on 8/13/03. PT notes, that were submitted, begin on 12/11/03; therefore, dates up to this point cannot be found to be medically necessary as they were not documented. The note of 9/9/03 indicates that as of Sept. 15, 2003 the patient should be able to resume PT activities. Accepted post-surgical guidelines for a rotator cuff repair with arthroscopy indicate that a 12 week program is standard. However, the patient had a second surgical repair to the cervicothoracic spine to remove the fractured spinous process. This is a definite complicating factor according to the MDA by Presley Reed, MD. By convention, this could lead to up to 1 ½ times the normal rehabilitation time for such an injury. Therefore, up to eighteen weeks of rehabilitation is acceptable. The records do not indicate when the PT began; therefore, for purposes of this review the reviewer assumes a begin date of 9/15/03. With this logic, an end date of PT would be set at a maximum of 2/1/04. Weekly office visits during the rehabilitation protocol are within normally accepted medical standards; therefore, they are approved as provided above. Passive therapies including: E-stim attended, hot/cold packs, manual therapies, massage and ultrasound are not medically necessary according to the submitted documentation.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO
CC: Specialty IRO Medical Director