

MDR Tracking Number: M5-05-1122-01

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 12-10-04.

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 \$650.00** 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 office visit level II and neuromuscular reeducation from 4-1-04 through 6-11-04 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 1-28-05 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 on 4-1-04, 4-2-04, 4-5-04, 4-6-04, 4-7-04, 4-8-04, 4-12-04, 4-16-04, 4-20-04, 4-22-04, 4-23-04, 4-26-04, 4-28-04, 4-30-04, 5-3-04, 5-5-04, 5-10-04, 5-12-04, 5-14-04, 5-17-04, 5-19-04, 5-21-04, 5-24-04, 5-26-04, 5-28-04, 6-1-04, 6-8-04, 6-9-04 and 6-11-04 was denied by the carrier as "N" – not documented. Review of the Daily Progress notes submitted reveals that documentation does meet the criteria set forth by the CPT Code descriptor. The level of service billed is supported in the requestor's position paper. **Recommend reimbursement of \$983.10 (\$33.90 x 29 DOS).**

CPT code 97032 on 4-1-04, 4-2-04, 4-5-04, 4-6-04, 4-7-04, 4-8-04, 4-12-04, 4-16-04 and 4-20-04 was denied by the carrier as "N" – not documented. Review of the Daily Progress notes submitted reveals that documentation does meet the criteria set forth by the CPT Code descriptor. The level of service billed is supported in the requestor's position paper. **Recommend reimbursement of \$180.36 (\$20.04 X 9 DOS).**

CPT code 97035 on 4-1-04, 4-2-04, 4-5-04, 4-6-04, 4-7-04 and 4-8-04 was denied by the carrier as "N" – not documented. Review of the Daily Progress notes submitted reveals that documentation does meet the criteria set forth by the CPT Code descriptor. The level of service billed is supported in the requestor's position paper. **Recommend reimbursement of \$93.36 (\$15.56 X 6 DOS).**

CPT code 97110 on 4-22-04, 4-23-04, 4-26-04, 4-28-04, 4-30-04, 5-3-04, 5-5-04, 5-10-04, 5-12-04, 5-14-04, 5-17-04, 5-19-04, 5-21-04, 5-24-04, 5-26-04, 5-28-04, 6-1-04, 6-8-04, 6-9-04 and 6-11-04 was denied by the carrier as "N" – not documented. 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. **Reimbursement not recommended.**

CPT code 97112 on 6-1-04, 6-8-04, 6-9-04 and 6-11-04 was denied by the carrier as "N" – not documented. Review of the Daily Progress notes submitted reveals that documentation does meet the criteria set forth by the CPT Code descriptor. The level of service billed is supported in the requestor's position paper. **Recommend reimbursement of \$146.76 (\$36.69 x 4 DOS).**

This Finding and Decision is hereby issued this 23rd day of February 2005.

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 4-1-04 through 6-11-04 as outlined above in this dispute.

This Order is hereby issued this 23rd day of February 2005.

Margaret Ojeda, Supervisor
Medical Dispute Resolution
Medical Review Division

MO/da

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

February 16, 2005

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 #: M5-05-1122-01
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 §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 TMF physician reviewer who is board certified in Family Practice which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1978. The TMF physician reviewer 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 61 year-old male injured his right shoulder on ___ while lifting a bucket of cement. As he was lifting he felt his right shoulder give way and felt sudden pain. He also complains of pain in his neck. He has been treated with surgery, medications and therapy.

Requested Service(s)

Office visit – level II and neuromuscular reeducation for dates of service 04/01/04 through 06/11/04

Decision

It is determined that there is medical necessity for the office visit – level II and neuromuscular reeducation for dates of service 04/01/04 through 06/11/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient injured his shoulder on ____. The office visits were necessary for the evaluation of the injury and progress with therapy. The neuromuscular reeducation was medically necessary to address the decreased range of motion in hopes of returning some function to his shoulder. It was later determined that surgery was necessary to repair the severe rotator cuff injury. Therefore, the office visit – level II and neuromuscular reeducation for dates of service 04/01/04 through 06/11/04 were medically necessary to treat this patient's medical condition.

Sincerely,



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

GBS:dm

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-1122-01

Information Submitted by Requestor:

- Progress Notes
- Diagnostic Tests
- Procedure Notes
- Consult
- Utilization Review
- Letter of Medical Necessity
- Claims

Information Submitted by Respondent:

- Progress Notes
- Procedure Report
- Medical Review
- Diagnostic Tests
- Durable Medical Equipment
- Claims