MDR Tracking Number: M5-03-1718-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution-General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 3-17-03.

The IRO reviewed office visits, myofascial release, therapeutic procedure, ultrasound, physical medicine treatment, data analysis, and special reports from 5-20-02 through 5-31-02, 6-20-02 through 7-19-02, and 8-5-02 through 8-21-02.

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.

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 June 26, 2003, the Medical Review Division submitted a Notice to the 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$ (Maximum Allowable Reimbursement)	Reference	Rationale
6-13-02	99080-73	15.00	0.00	C	15.00	96 MFG Med GR and Rule 129.5 and 133.307(g)(3)	Letter dated 1-13-04 from requestor states they do not have a contract with the carrier. Review will be per the MFG only. The requestor did not provide relevant documentation. No reimbursement recommended.
6-17-02 6-20-02 6-24-02 6-26-02 6-28-02 8-27-02	99213	50.00 x 6	0.00	F	48.00	96 MFG E/M GR VI B	Patient Office Visit Reports for these dates of service support services rendered. Recommend reimbursement of $288.00.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
6-18-02	97750-MT	129.00	86.00	R	43.00 per body area	96 MFG I E 3	Contested Case Hearing decision states only compensable injury is left knee and left ankle. Form 97750-MTM includes muscle testing to lumbar; therefore, no review can be made for the lumber.
7-22-02	99080 (106 pages of medical records)	53.00	0.00	No EOB	.50 per page	133.106 (f) (3)	Patient Office Visit Report supports 106 copies made. Recommend reimbursement of $53.00
7-25-02	99215 95851 knee 95851 cerv 95851 lumb 97750-MT 99080-73	125.00 40.00 40.00 40.00 301.00 15.00	0.00		103.00 36.00 36.00 36.00 43.00 ea body area 15.00	96 MFG E/M GR VI B; Rule 129.5; I E 3; CPT descriptor and 133.307 (g)(3)	Patient Office Visit Report and ROM reports support services rendered. Recommend reimbursement of $211.00. Relevant documentation was not submitted to support delivery of service for muscle testing or required report. No reimbursement recommended.
7-26-02 8-14-02	97750-MT	86.00x2	0.00		43.00 ea body area	96 MFG I E 3	Form 97750-MTM supports delivery of service. Recommend reimbursement of $172.00.
7-29-02	99213 97250 97265	50.00 43.00 43.00	0.00		48.00 43.00 43.00	96 MFG E/M GR VI B; I A 10 a	Patient Office Visit Report supports services rendered. Recommend reimbursement of $134.00.
7-31-02 8-2-02	99213 97250 97265 97110 97150	50.00x2 43.00x2 43.00x2 35.00x6 27.00x2	0.00		48.00 43.00 43.00 35.00 ea 15 min 27.00	96 MFG E/M GR VI B; I A 10 a	Patient Office Visit Report supports services rendered. Recommend reimbursement of $161.00. See RATIONALE below for code 97110.
TOTAL		1902.00	0.00				The requestor is entitled to reimbursement of $731.00

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.

The above Findings and Decision are hereby issued this 21st day of January 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

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 3-22-02 through 7-12-02 in this dispute.

This Order is hereby issued this 21st day of January 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dzt

NOTICE OF INDEPENDENT REVIEW DECISION

June 24, 2003

MDR Tracking #:	M5-03-1718-01
IRO Certificate #:	IRO4326

___ 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 ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional 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 ___ 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 patient works as a housekeeper in a motel. While working in the laundry room, on ___, she slipped and fell, landing on her low back, hitting her head, and twisting her left leg. Her MRI on 03/21/02 revealed a medial meniscal abnormality. She subsequently had a left knee arthroscopy on 04/19/02. The patient had seen a chiropractor both before and after her surgery for physical therapy.

Requested Service(s)

Myofascial release, therapeutic procedure, ultrasound therapy, physical medicine treatment, data analysis, office visit, and special reports from 05/20/02 through 05/31/02, 06/20/02 through 07/19/02, and 08/05/02 through 08/21/02

Decision

It is determined that the myofascial release, therapeutic procedure, ultrasound therapy, physical medicine treatment, data analysis, office visit, and special reports from 05/20/02 through 05/31/02, 06/20/02 through 07/19/02, and 08/05/02 through 08/21/02 were medically necessary to treat this patient's condition

Rationale/Basis for Decision

The patient underwent left knee arthroscopy on 04/19/02. The surgeon recommended post-surgical physical therapy. Treatment was performed and per the medical record, the patient responded favorably. Each visit was properly documented with subjective symptoms, objective findings, assessment, and plan. There was documented improvement in range of motion and muscle strength. She experienced an exacerbation of pain at one point and required additional care.

Her improvement began to plateau and she was scheduled on an "as needed" basis". She was able to return to work with restrictions, further evidence of the efficacy of the therapy provided her. The injury was treated appropriately and resulted in a successful outcome. Therefore, it is determined that the myofascial release, therapeutic procedure, ultrasound therapy, physical medicine treatment, data analysis, office visits, and special reports from 05/20/02 through 05/31/02, 06/20/02 through 07/19/02, and 08/05/02 through 08/21/02 were medically necessary.

Sincerely,