THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO: 453-04-2824.M5

MDR Tracking Number: M5-03-1892-01

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. This dispute was received on April 2, 2003.

The IRO reviewed office visits with manipulations, ultrasound therapy, myofascial release, electrical stimulation, joint mobilization, radiological exam, special services report, and therapeutic procedures rendered from 08-12-02 through 12-18-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for office visits with manipulations, ultrasound therapy, myofascial release, electrical stimulation, joint mobilization, radiological exam, special services report, and therapeutic procedures. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 2, 2003, 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. The respondent's statement of position indicates a TWCC 21 was filed disputing compensability/ extent issue, however the respondent did not provide a copy of this document. Review of the TWCC 21 database does not show receipt of a TWCC 21 disputing compensability or extent issues. On the basis the CPT codes listed in the following table will be review in accordance with the Medical Fee Guideline.

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
12/05/02	99213-MP	48.00	0.00	F	48.00	MFG, MGR (I)(B)(1)(b)	SOAP notes confirm delivery of service as billed. Reimbursement recommended $48.00
12/05/02	97265	43.00	0.00	F	43.00	MFG, MGR (I)(C)(3)	SOAP notes do not confirm delivery of service as billed. No reimbursement recommended

12/05/02	97250	43.00	0.00	F	43.00	MFG, MGR (I)(C)(3)	SOAP notes do not confirm delivery of service as billed. No reimbursement recommended
12/05/02 12/05/02 12/05/02	97110 97110 97110	40.00 40.00 40.00	0.00 0.00 0.00	F F F	35.00 35.00 35.00	MFG, MGR (I)(A)(9)(b)	See rational below *
12/05/02 12/5/02	97032 97032	22.00 22.00	0.00	F	22.00 22.00	MFG, MGR (I)(A)(9)(a)(ii)	SOAP notes confirm delivery of service as billed. Recommended reimbursement $44.00 SOAP notes confirm delivery of service as billed.
TOTAL		$298.00					The requestor is entitled to reimbursement of **$**92.00

*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 MRD declines to order payment because: the requestor did not document that the injury was severe enough to warrant one-to-one therapy, nor did the requestor document the procedure was done in a one-to-one setting. 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 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 12-5-02 in this dispute.

This Decision is hereby issued this 5th day of January 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

May 28, 2003

MDR Tracking #: M5-03-1892-01
IRO Certificate #:IRO 4326

The ___ 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 sustained an injury to his left knee on ___ when he was struck by a vehicle while sweeping the road. He initially saw a chiropractor for therapy but was making little progress. An MRI was performed on 08/29/02 which revealed a high-grade tear of the anterior cruciate ligament (ACL) and superior portion of the posterior cruciate ligament (PCL), probable tear of the posterior horn of the lateral meniscus, and partial tear and partial avulsion of the proximal medial collateral ligament. The patient underwent surgery on 10/08/02 and continued to see the chiropractor for post-operative therapy.

Requested Service(s)
Office visits with manipulation, ultrasound therapy, myofascial release, electrical stimulation, joint mobilization, radiological exam, special services report, and therapeutic procedure from 08/12/02 through 12/18/02

Decision
It is determined that the office visits with manipulation, ultrasound therapy, myofascial release, electrical stimulation, joint mobilization, radiological exam, special services report, and therapeutic procedure from 08/12/02 through 12/18/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision
This patient experienced signs and symptoms of significant injury to his left knee as a result of the accident. When he initiated care with the orthopedic physician, he had already completed four weeks of conservative care to his knee. This period of four weeks would constitute a typical 4-week trial of conservative care consistent with multi-disciplinary standards to treat soft tissue injuries of the knee with suspicion of internal derangement. Beyond four weeks with no measurable objective therapeutic gain, an additional course of conservative care would not be considered as medically necessary as of 08/12/02. The medical record does not indicate that the patient made satisfactory therapeutic gain during the course of care offered in relation to treatment of the left knee. Although the dates from 08/12/02 through 12/18/02 included the timeframe involving post operative care, it is not evident that the orthopedic surgeon ever recommended a formal course of rehabilitative care outside of the home exercise program that was given the patient after surgery.

Therefore, it is determined that the office visits with manipulation, ultrasound therapy, myofascial release, electrical stimulation, joint mobilization, radiological exam, special services report, and therapeutic procedure from 08/12/02 through 12/18/02 were not medically necessary.

Sincerely,