MDR Tracking Number: M5-03-1922-01

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, 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 4-7-03.

The IRO reviewed medical records, myofascial release, joint mobilization, therapeutic exercises, office visits, and group therapeutic procedures rendered from 6-27-02 to 12-19-02 that were denied based upon "U" and "V".

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.

The IRO concluded that the medical records, myofascial release, joint mobilization, therapeutic exercises, office visits, group therapeutic procedures were medically necessary from 6-27-02 through 10-1-02. The IRO concluded that myofascial release, joint mobilization, therapeutic exercises, office visits, and group therapeutic procedures from 10-2-02 through 12-19-02 were not medically necessary.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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
10/14/02	97110	280.00	0.00	G	35.00 ea 15 min	MFG Med. GR I A 9 b	Carrier denied this code as "G – this procedure is included in another procedure performed on this date." The carrier did not state the other procedure and this code is not global per the MFG ground rules or CPT descriptor. However, per the MFG, the

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
							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. See **RATIONALE** below. Therefore, no reimbursement recommended.
10/31/02	95851 (right wrist) 95851 (right finger)	40.00 40.00	0.00	F	36.00	MFG E/M GR IV A 1, Med GR I A 8, CPT descriptor	Carrier denied as "F – by clinical practice standards, this procedure is incidental to the related primary procedure billed." The carrier does not state the primary procedure billed and per the MFG, ROM testing can be reimbursed in addition to an office visit. Also, ROM testing is not considered global unless performed by a PT or OT. The Patient Office Visit Report dated 10-31-02 supports delivery of service and was signed by a DC. Therefore, recommend reimbursement of $36.00 x 2 = $72.00.
TOTAL		360.00	0.00				The requestor is entitled to reimbursement of **$72.00.**

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 because the Patient Office Visit Report and the "Therapeutic Procedures Chart" dated 10-14-02 did not indicate whether the doctor was conducting exclusively one-to-one sessions with the claimant, did not clearly indicate activities that would require a one-on-one therapy session, the notes did not reflect the need for one-on-one supervision and there was no statement of the claimants medical condition or symptoms that would mandate one-on-one supervision for an entire session or over an entire course of treatment.

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 6-27-02 through 10-31-02 in this dispute.

This Order is hereby issued this 19th day of December 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

December 22, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

Corrected Letter

RE: MDR Tracking #: M5-03-1922-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ 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. 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 41 year-old male who sustained a work related injury on ___. The patient reported that while at work he was opening boxes when he began to feel a tingling and pain in the base of the right thumb and wrist. The patient underwent X-Rays and an MRI of the right thumb and wrist. The diagnoses for this patient include tenosynovitis of right hand and wrist. The patient has been treated with active and passive physical therapy.

Requested Services

Medical records, myofascial release, joint mobilization, therapeutic exercises, office visits, group therapeutic procedures and range of motion from 6/27/02 through 12/19/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 41 year-old male who sustained a work related injury to his right thumb and wrist on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included tenosynovitis of the right hand and wrist. The ___ chiropractor reviewer further noted that the patient has been treated with active and passive physical therapy. The ___ chiropractor reviewer explained that after a review of the medical records provided the treatment from 10/1/02 through 12/19/02 was not medically necessary. The ___ chiropractor reviewer also explained that the patient failed to make additional progress in his condition after 10/1/02. The ___ chiropractor reviewer indicated that this patient's symptoms increased after the long course of physical therapy. The ___ chiropractor reviewer explained that by 10/1/02 the treatment for this patient should have changed to address the patient's increased symptoms. Therefore, the ___ chiropractor consultant concluded that the medical records, myofascial release, joint mobilization, therapeutic exercises, office visits, group therapeutic procedures and range of motion from 6/27/02 through 10/1/02 was medically necessary to treat this patient's condition. However, the ___ chiropractor consultant concluded that the medical records, myofascial release, joint mobilization, therapeutic exercises, office visits, group therapeutic procedures and range of motion from 10/2/02 through 12/9/02 were not medically necessary to treat this patient's condition.

Sincerely,

___