MDR Tracking Number: M5-03-2311-01

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 5-15-03.

The IRO reviewed office visits, electrical stimulation, therapeutic exercises, diathermy, myofascial release, joint mobilization, muscle testing, and group therapeutic procedures rendered from 6-3-02 through 10-9-02 that were denied as not medically necessary.

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 August 7, 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 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
6-28-02	99070 (TENS supply)	25.00	0.00	No EOB	DOP	96 MFG GI, III, IV	No documentation was submitted to support service rendered. No reimbursement recommended.
7-2-02 8-29-02	99080-73	15.00	0.00	G	15.00	96 MFG Med GR, CPT descriptor & Rule 129.5	This rule requires the doctor to file a work status report and is not global to any other service. Work Status Report for these two dates of service were not submitted. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
9-6-02 thru 9-18-02	99213 97265 97250 97110 97150	50.00 x 6 43.00 x 6 43.00 x 6 210.00 x 2 245.00 x 4 27.00 x 6	0.00	No EOB	48.00 43.00 43.00 35.00 ea 15 min 27.00	96 MFG E/M GR IV C 2; Med GR I A 9 b; I C 3	Patient Office Visit Reports and Therapeutic Procedures Chart dated 9-6-02, 9-9-02, 9-11-02, 9-13-02, 9-16-02, and 9-18-02 support office visits, joint mobilization, myofascial release and group therapeutic procedures. The Therapeutic Procedure Chart was not submitted for 9-18-02; therefore no reimbursement recommended for group therapeutic procedures for this date. Recommend reimbursement of $939.00.
9-19-02	97750-MT	172.00	0.00	No EOB	43.00 per body area	96 MFG Med GR I D, I E 3	Muscle testing report dated 9-19-02 supports testing of two body areas. Recommend reimbursement of $86.00.
10-2-02	99213 97265 97250 97110 97150	50.00 43.00 43.00 245.00 27.00	0.00	C	48.00 43.00 43.00 35.00 ea 15 min 27.00	96 MFG E/M GR IV C 2; Med GR I A 9 b; I C 3	Carrier denied as "C – negotiated contract price" but paid $0.00. Requestor did not challenge carrier's denial rationale. Neither party submitted a copy of a negotiated contract. Therefore, no reimbursement recommended.
TOTAL		2958.00	0.00				The requestor is entitled to reimbursement of $1213.00.

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 97110 because the daily notes did not clearly indicate activities that would require exclusive one-on-one therapy sessions.

The above Decision is hereby issued this 7th 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 6-3-02 through 10-9-02 in this dispute.

This Order is hereby issued this 7th day of January 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dzt

July 22, 2003

IRO Certificate #5259
MDR Tracking Number: M5-03-2311-01

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
___, a 74-year old man, had shoulder surgery ___. His post surgical rehab was effective; he was released to home management for continued self-therapy. Upon re-examination it was determined that home therapy was ineffective and he was brought back into clinical setting for more hands on care.

REQUESTED SERVICE (S)
Therapeutic exercises, diathermy, electrical stem, myofascial release joint mobilization, office visit, muscle testing, and group therapeutic procedure

DECISION
These procedures were medically necessary.

RATIONALE/BASIS FOR DECISION
The primary goal of post surgical rehab was to increase the range of motion in ___ right shoulder after his acromioclavicular surgery. Clinically, this rehab usually results in increased muscle strength as well as having the level of pain diminish as the range of motion increases. This is a 74-year old man who is performing repetitive motions at work. The recovery can be expected to be long term. Based on my review of the records presented, the treatment plan is within medical guidelines and standards. ___ was improving with his rehab, he was allowed to transition into home based therapy which proved to be ineffective upon re-examination. Therefore, he was taken back into a more controlled environment where he again had marked improvement. As for the modalities, these are essential for this type of rehab process. Therapeutic exercise is the cornerstone of this program. Diathermy increases total metabolism, increases membrane diffusion, increase enzymatic activity, and oxygen demand, increases vasodilation for waste removal. Since this is a superficial region, this therapy works very well. Electrical stem has a very good sensory component for neutral stimulation as well as an analgesic effect depending upon the Hz cycle used. Myofascial release and joint mobilization are paramount for normalization of soft tissue in order to prevent fribrosis. This joint must be taken into the paraphysiological space through manipulation in order to maximize the range of motion of any joint. Muscle testing, therapeutic procedures, and group therapeutic exercises are beneficial for any de-conditioned patient and based on my review and the age of the patient these procedures are warranted.