MDR Tracking Number: M5-03-2342-01

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 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 05-19-03.

The IRO reviewed therapeutic procedures, office visits, office visits with manipulation, myofascial release, joint mobilization, manual traction, X-ray, sensory nerve conduction testing, muscle testing, range of motion, FCE, work hardening and team conference rendered from 11-21-02 through 03-24-03 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

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 08-14-03, 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$	Reference	Rationale
11-25-02 through 12-10-02 (3 DOS)	99213	$144.00 (1 unit @ $48.00 X 3 DOS)	$0.00	No EOB	$48.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $48.00 X 3 DOS = $144.00
11-25-02 through 12-10-02 (3 DOS)	97265	$129.00 (1 unit @ $43.00 X 3 DOS)	$0.00	No EOB	$43.00	Rule 133.307(g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $43.00 X 3 DOS = $129.00
11-25-02	97250	$129.00	$0.00	No	$43.00	Rule 133.307	Requestor submitted

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
through 12-10-02 (3 DOS)		(1 unit @ $43.00 X 3 DOS)		EOB		(g)(3)(A-F)	relevant information to support delivery of service. Reimbursement recommended in the amount of $43.00 X 3 DOS = $129.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
11-25-02 through 12-10-02 (3 DOS)	97122	$105.00 (1 unit @ $35.00 X 3 DOS)	$0.00	No EOB	$35.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $35.00 X 3 DOS = $105.00
11-25-02 through 12-10-02 (3 DOS)	97110	$420.00 (4 units @ $35.00 per unit X 3 DOS)	$0.00	No EOB	$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
11-26-02	95851	$36.00 (1 unit)	$0.00	No EOB	$36.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $36.00
11-25-02	97750-MT	$43.00	$0.00	No EOB	$43.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $43.00
2-14-03 through 2-18-03 (2 DOS)	97545-WH	$256.00 (1 unit @ $128.00 X 2 DOS)	$0.00	No EOB	$64.00 per hour	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $64.00 X 2 DOS = $128.00
2-14-03 through 2-18-03	97546-WH	$768.00 (6 units @ 384.00 X 2	$0.00	No EOB	$64.00 per hour	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
		DOS)					recommended in the amount of $64.00 X 12 units = $768.00
TOTAL		$2,030.00	$0.00		$1,902.00		The requestor is entitled to reimbursement in the amount of $1,482.00

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.

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 11-21-02 through 03-24-03 in this dispute.

This Order is hereby issued this 30th day of March 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

August 12, 2003
Amended March 29, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5 03 2342 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

This patient was injured on his job when he twisted his back and caused an onset of low back pain while lifting. He was treated at ___ with extensive chiropractic, passive and active care. MRI of the lumbar spine revealed a slight spinal stenosis at L3/4, L4/5 and L5/S1 due to disk bulging at those levels. No frank disc herniation is noted in the report by ___. CPT testing was demonstrative of slight sensory loss. A peer review by ___ stated that care was not reasonable or necessary after September 3, 2002, but did recommend post-injection therapy.

DISPUTED SERVICES

The carrier has denied the medical necessity of therapeutic procedures, office visits with manipulation, myofascial release, joint mobilization, manual traction, X-ray, sensory nerve conduction testing, muscle testing, range of motion, FCE, work hardening and team conferencing as medically unnecessary for the dates 11/21/2002, 12/2/2002-12/5/2002, 12/12/2002-2/13/2003, 2/17/2003, 2/19/2003-2/28/2003 and 3/3/2003-3/24/2003.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The very high amount of utilization on this case is not found to be medically necessary. There is no evidence that this patient suffered from a condition that would require treatment of almost a year, with dates of service continuing to include both passive and active care for much of that time. The work hardening program is not demonstrated to have been of benefit to this patient by the documentation presented. Mercy Guidelines and the Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters are greatly exceeded by this treatment protocol without reasoning explained by the treating clinic. As a result, medical necessity is not established for the disputed dates of service on this case.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,