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

SOAH DOCKET NO. 453-04-5801.M5

MDR Tracking Number: M5-03-2358-01

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 05-21-03.

The IRO reviewed muscle testing, range of motion, joint mobilization, myofascial release, group therapy procedures, therapeutic exercises, office visits, analgesic balm, diathermy, massage and special reports rendered from 07-23-02 through 10-24-02 that was 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. 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 08-07-03, 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
7-24-02 through 12-16-02 (7 DOS)	97265	$301.00 ($43.00 1 unit X 7 DOS)	$0.00	F, No EOB	$43.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of $43.00 X 7 DOS = $301.00
8-16-02 through 11-18-02 (3 DOS)	97265	$129.00 ($43.00 1 unit X 3 DOS)	$0.00	N,R	$43.00	96 MFG MED GR (I)(C)(3)	N – Requestor submitted relevant information to meet documentation criteria for all DOS. R-TWCC 21 on file denies

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
							compensability for treatment of hypertension. Diagnosis of hypertension not billed. Reimbursement recommended in amount of $43.00 X 3 DOS = $129.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
7-24-02 through 9-18-02 (8 DOS)	97110	$1960.00 ($175.00 5 units X 1 DOS, $280.00 8 units X 3 DOS, $245.00 7 units X 3 DOS, $210.00 6 units X 1 DOS)	$840.00 ($35.00 X 24 units)	F, No EOB, N, R	$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended. R- TWCC 21 on file denies compensability for hypertension. Diagnosis of hypertension not billed.
8-12-02	97750-MT	$129.00 ($43.00 per unit X 3 units)	$0.00	N,R	$43.00	96 MFG MED GR (I)(E)(3)	N – Requestor submitted relevant information to meet documentation criteria. R – TWCC 21 on file denies compensability for hypertension. Diagnosis of hypertension not billed. Reimbursement recommended in amount of $43.00 X 3 units = $129.00
12-16-02	99213	$50.00	$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 amount of $48.00
8-16-02 through 8-21-02 (3 DOS)	99213	$150.00 ($50.00 1 unit X 3 DOS)	$0.00	N,R	$48.00	96 MFG E/M GR (VI)(B)	N – Requestor submitted relevant information to meet documentation criteria. R – TWCC 21 on

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
							file denies compensability for hypertension. Diagnosis of hypertension not billed. Reimbursement recommended in amount of $48.00 X 3 DOS = $144.00
8-16-02 through 8-19-02 (2 DOS)	97150	$54.00 ($27.00 1 unit X 2 DOS)	$0.00	N,R	$27.00	96 MFG MED GR (I)(10)	N – Requestor submitted relevant information to meet documentation criteria. R- TWCC 21 on file denies compensability for hypertension. Diagnosis of hypertension not billed. Reimbursement recommended in amount of $27.00 X 2 DOS = $54.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
8-16-02 through 12-16-02 (5 DOS)	97250	$215.00 ($43.00 1 unit X 4 DOS)	$0.00	No EOB, N,R	$43.00	96 MFG MED GR (I)(10)	N – Requestor submitted relevant information to meet documentation criteria. R – TWCC 21 on file denies compensability for hypertension. Diagnosis of hypertension not billed. Reimbursement recommended in amount of $43.00 X 5 DOS = $215.00
9-3-02	99080-73	$15.00 (1 unit)	$0.00	N	DOP	96 MFG General Instructions (III)(A)	Requestor did not submit relevant information to meet documentation criteria set forth by the Medical Fee Guideline. No reimbursement recommended.
11-18-02 through 12-16-02	97124	$40.00 ($20.00 1 unit X 2	$0.00	N, No EOB	$28.00	96 MFG MED GR (I)(10)(a)	Requestor submitted relevant information to meet documentation

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
(2 DOS)		DOS)					criteria. Reimbursement recommended in amount of $28.00 X 2 DOS = $56.00
11-18-02 through 12-16-02 (2 DOS)	97014	$34.00 ($17.00 1 unit X 2 DOS)	$0.00	N, No EOB	$15.00	96 MFG GR (I)(9)(a)(ii)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in amount of $15.00 X 2 DOS = $30.00
TOTAL		$3,041.00	$840.00		$2,821.00		The requestor is entitled to reimbursement in the amount of $1,106.00

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 07-23-02 through 12-16-02 in this dispute.

This Order is hereby issued this 26th day of March 2004.

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

August 4, 2003 **REVISED**

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

MDR Tracking #: M5 03 2358 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 while working as a gardener at ___. He was trimming bushes that were about 12 feet tall and he was unable to reach the top of the bushes. As a result, he stood in the back of an ATV, which collapsed, causing him to drop downward. The action of the fall also allowed the opposite side of the bucket to hit ___ the low back region and left elbow. Initially he was treated by ___ and later changed to ___. Records presented indicate that radiographic studies and EMG results were negative for pathology on this case.

DISPUTED SERVICES

The carrier has disputed the medical necessity of muscle testing, range of motion, joint mobilization, myofascial release, group therapy procedures, therapeutic exercises, office visits, analgesic balm, diathermy, massage, and special reports.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The documentation presented was extensive, but it did not demonstrate that the patient had ongoing need for this extensive amount of care. Records do indicate that the patient was treated for upwards of 50 office visits with physical medicine for a sprain/strain type of injury. On each visit was very extensive exercise and PT that is not determined to be necessary due to the diagnosis of this patient combined with the lack of objective evidence that there is organic disturbance in this patient's spine. Carrier records indicate that 27 office visits with therapy were authorized on this case.

That is a reasonable amount of treatment on a case such as this, but the reviewer sees no justification of an advanced amount of treatment on a case without reasonable cause for the treatment. As a result, I must find that the treatment rendered is not medically necessary.

___ 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,