THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: 453-04-7291.M5

MDR Tracking Number: M5-03-2479-01

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 06-04-03.

The IRO reviewed manipulations, hot/cold pack therapy, electrical stimulation, therapeutic procedures, therapeutic activities, myofascial release, ultrasound therapy, office visits and required reports rendered from 09-09-02 through 09-11-02, and 10-04-02 through 01-27-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$**	**Reference**	**Rationale**
10-8-02 through 11-29-02 (8 DOS)	97260	$360.00 (1 unit @ $45.00 X 8 DOS)	$0.00	U	$35.00	IRO DECISION	IRO recommended reimbursement in the amount of $35.00 X 8 DOS = $280.00
9-9-02 through 11-29-02 (28 DOS)	97261	$420.00 (1 unit @ $15.00 X 28 DOS)	$0.00	U	$8.00	IRO DECISION	IRO recommended reimbursement in the amount of $88.00 X 28 DOS = $224.00
10-18-02 through 11-29-02 (17 DOS)	99211	$510.00 (1 unit @ $30.00 X 17 DOS)	$0.00	U	$18.00	IRO DECISION	IRO recommended reimbursement in the amount of $18.00 X 17 DOS = $306.00
10-18-02 through 11-29-02 (16 DOS)	97250	$636.48 (1 unit @ $39.78 X 16 DOS)	$0.00	U	$43.00	IRO DECISION	IRO recommended reimbursement in the amount of $39.78 X 16 DOS = $636.48

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
10-18-02 through 11-29-02 (17 DOS)	97010	$255.00 (1 unit @ $15.00 X 17 DOS)	$0.00	U	$11.00	IRO DECISION	IRO recommended reimbursement in the amount of $11.00 X 17 DOS = $187.00
10-18-02 through 11-29-02 (17 DOS)	97014	$425.00 (1 unit @ $25.00 X 17 DOS)	$0.00	U	$15.00	IRO DECISION	IRO recommended reimbursement in the amount of $15.00 X 17 DOS = $255.00
10-18-02 through 11-29-02 (17 DOS)	97035	$255.00 (1 unit @ $15.00 X 17 DOS)	$0.00	U	$22.00	IRO DECISION	IRO recommended reimbursement in the amount of $15.00 X 17 DOS = $255.00
10-18-02 through 11-29-02 (17 DOS)	97530	$2,380.00 (1 unit @ $35.00 X 68 units)	$0.00	U	$35.00	IRO DECISION	IRO recommended reimbursement in the amount of $35.00 X 68 units = $2,380.00
10-18-02 through 11-29-02 (17 DOS)	97110	$1,920.00 (1 unit @ $30.00 X 64 units)	$0.00	U	$35.00	IRO DECISION	IRO recommended reimbursement in the amount of $30.00 X 64 units = $1,920.00
12-2-02	97260	$45.00 (1 unit)	$0.00	U	$35.00	IRO DECISION	Reimbursement not recommended by IRO
12-2-02 through 1-27-03 (19 DOS)	97261	$555.00 (1 unit @ $15.00 X 37 units)	$0.00	U	$8.00	IRO DECISION	Reimbursement not recommended by IRO
12-2-02 through 1-27-03 (19 DOS)	99211	$570.00 (1 unit @ $30.00 X 19 DOS)	$0.00	U	$18.00	IRO DECISION	Reimbursement not recommended by IRO
12-2-02 through 1-27-03 (16 DOS)	97250	$636.48 (1 unit @ $39.78 X 16 DOS)	$0.00	U	$43.00	IRO DECISION	Reimbursement not recommended by IRO
12-2-02	97010	$285.00	$0.00	U	$11.00	IRO	Reimbursement not recommended by

through 1-27-03 (19 DOS)		(1 unit @ $15.00 X 19 DOS)				DECISION	IRO
12-2-02 through 1-27-03 (19 DOS)	97014	$475.00 (1 unit @ $25.00 X 19 DOS)	$0.00	U	$15.00	IRO DECISION	Reimbursement not recommended by IRO
12-2-02 through 1-27-03 (17 DOS)	97035	$255.00 (1 unit @ $15.00 X 17 DOS)	$0.00	U	$22.00	IRO DECISION	Reimbursement not recommended by IRO
12-2-02 through 1-27-03 (16 DOS)	97530	$2,240.00 (1 unit @ $35.00 X 64 units)	$0.00	U	$35.00	IRO DECISION	Reimbursement not recommended by IRO

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$**	**Reference**	**Rationale**
12-2-02 through 1-27-03 (19 DOS)	97110	$2,100.00 (1 unit @ $30.00 X 70 units)	$0.00	U	$35.00	IRO DECISION	Reimbursement not recommended by IRO
1-21-03	99080	$15.00 (1 unit)	$0.00	U	$15.00	IRO DECISION	Reimbursement not recommended by IRO
TOTAL		$14,338.00					The requestor is entitled to reimbursement of **$6,443.00**

The IRO concluded that manipulations, hot/cold pack therapy, electrical stimulation, therapeutic procedures, therapeutic activities, myofascial release, ultrasound therapy, office visits and required reports from 12-02-02 through 01-27-03 **were not** medically necessary. The IRO concluded that manipulations, hot/cold pack therapy, electrical stimulation, therapeutic procedures, therapeutic activities, myofascial release, ultrasound therapy and office visits from 09-09-02 through 11-29-02 **were** medically necessary.

On this basis, the total amount recommended for reimbursement (**$6,443.00**) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 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
9-20-02 through 10-16-02 (8 DOS)	97260	$495.00 (1 unit @ $45.00 X 11 units)	$0.00	D	$35.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent provided the original denial information. Reviewer cannot determine reason for denial. No reimbursement recommended
9-20-02 through 10-16-02 (9 DOS)	97010	$270.00 (1 unit @ $15.00 X 18 units)	$0.00	D	$11.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent provided the original denial information. Reviewer cannot determine reason for denial. No reimbursement recommended

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
9-20-02 through 10-16-02 (9 DOS)	97014	$300.00 (1 unit @ $25.00 X 12 units)	$0.00	D	$15.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent provided the original denial information. Reviewer cannot determine reason for denial. No reimbursement recommended
9-20-02 through 10-14-02 (7 DOS)	97530	$490.00 (1 unit @ $35.00 X 14 units)	$0.00	D	$35.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent provided the original denial information. Reviewer cannot determine reason for denial. No reimbursement recommended
9-20-02 through 10-14-02 (8 DOS)	97110	$420.00 (1 unit @ $30.00 X 14 units)	$0.00	D	$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended
10-9-02	99211	$30.00 (1 unit)	$0.00	D	$18.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent provided the original denial information. Reviewer cannot determine reason for denial. No reimbursement recommended
10-9-02 10-16-02 (2 DOS)	97250	$79.56 (1 unit @ $39.78 X	$0.00	D	$43.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent provided the original denial information. Reviewer

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
		2 units)					cannot determine reason for denial. No reimbursement recommended
TOTAL		$2,084.56	$0.00				Requestor is not entitled to any reimbursement.

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.

This Decision is hereby issued this 26th day of May 2004.

Debra L. Hewitt
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 10-08-02 through 11-29-02 in this dispute.

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

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

May 18, 2004

REVISED REPORT
Corrected date in "Decision";
Add middle initial to injured worker's name.

MDR #: M5-03-2479-01
IRO Certificate No.: 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Certified in Chiropractic Medicine.

Clinical History:
This male claimant fell while on his job on ___, injuring his low back. He began conservative therapies on 08/14/02, and also received an MRI on 10/08/02. The MRI revealed a herniated nucleus pulposus (HNP) at L4-L5 and L5-S1. He was evaluated for surgery, and physical therapy was continued. He received two FCE's and has also undergone a work conditioning program. All of this was done prior to his undergoing surgery to his lumbar spine on 04/25/03.

Disputed Services:
Manipulations, hot/cold pack, electrical stimulation, therapeutic procedures, therapeutic activities, myofascial release, ultrasound, office visits, and required reports during the periods of 09/09/02 through 09/11/02, and 09/11/02, 10/04/02 through 01/27/03.

Decision:
The reviewer partially agrees with the determination of the insurance carrier in this case and is of the opinion that the services and treatments listed above were medically necessary as rendered during the period of 09/09/02 through 11/29/02. The services and treatments rendered during the remaining dates in question were not medically necessary.

Rationale:
This decision is based upon whether or not the therapies provided were necessary and within recognized treatment protocols, i.e., the Spinal Treatment Guidelines. It is evident from the notes provided that the patient was suffering from a significant injury to his lumbar spine as verified through exam and diagnostic imaging.

Due to this factor, an initial eight weeks of therapies was not sufficient to remedy his injury. Therefore, with the desire to exhaust all conservative care prior to surgery, continued care past the initial eight weeks was prudent.

However, on 11/13/02, the patient showed no improvement from the prior exam done on 10/29/02, and no other documentation of therapies was present. Therefore, it must be assumed that no further progress was recorded following the date of 11/13/02. According to TWCC Rule, when there is documented absence of change in the condition of the injured worker over a period of time of no less than one month, re-evaluation of the injured worker's condition is required, as

well as re-evaluation of the current treatment program. It is the reviewer's opinion that no further treatment past 11/29/03 would have been medically necessary in this case.

According to Texas Labor Code 408:021(a), an employee is entitled to the care reasonably required in association with their injury and the treatment thereof. If the patient's condition is not stable, the care to maintain and promote healing is medically necessary.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,