MDR Tracking Number: M5-03-2675-01

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 06-20-03.

The IRO reviewed functional capacity evaluation rendered on 09-16-02 and therapeutic procedure rendered from 12-05-02 through 12-26-02 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 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.

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 09-04-03, 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
6-27-02	95999	$384.00	$0.00	N	$384.00	96 MFG General Instructions (III)(A)	N -The requestor submitted relevant information to meet the documentation criteria set forth by the MFG for the unlisted procedure. Recommend reimbursement of $384.00
7-03-02	97750-MT	$43.00	$0.00	No EOB	$43.00	Rule 133.307 (g)(3)(A-F)	No EOB – MDR will review per Rule 133.307(g)(3)(A-F). The requestor submitted relevant information to support delivery of

							service. Recommend reimbursement of $43.00
7-3-02 to 7-11-02 (6 DOS)	99213	$48.00 (1 unit)	$0.00	No EOB	$288.00	Rule 133.307 (g)(3)(A-F)	No EOB – MDR will review per Rule 133.307(g)(3)(A-F). The requestor submitted relevant information to support delivery of service. Recommend reimbursement of $48.00 X 6 = $288.00
7-3-02 to 7-11-02 (6 DOS)	97110	$140.00 (4 units)	$0.00	No EOB	$840.00	Rule 133.307 (g)(3)(A-F)	No EOB – MDR will review per Rule 133.307(g)(3)(A-F). The requestor did not submit relevant information to clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy to support delivery of service. Reimbursement not recommended.
7-3-02 to 7-11-02 (6 DOS)	97265	$43.00 (1 unit)	$0.00	No EOB	$258.00	Rule 133.307(g)(3) (A-F)	No EOB – MDR will review per Rule 133.307(g)(3)(A-F). The requestor submitted relevant information to support delivery of service. Recommend reimbursement of $43.00 X 6 = $258.00
7-3-02 to 7-11-02 (6 DOS)	97250	$43.00 (1 unit)	$0.00	No EOB	$258.00	Rule 133.307(g)(3) (A-F)	No EOB – MDR will review per Rule 133.307(g)(3)(A-F). The requestor submitted relevant information to support delivery of service. Recommend reimbursement of $43.00 X 6 = 258.00
7-3-03 to 7-11-	97122	$35.00 (1 unit)	$0.00	No EOB	$210.00	Rule 133.307 (g)(3)(A-F)	No EOB – MDR will review per Rule

02 (6 DOS)							133.307(g)(3)(A-F). The requestor submitted relevant information to support delivery of service. Recommend reimbursement of $35.00 X 6 = $210.00
9-25-02 to 10-9-02 (3 DOS)	99213	$48.00 (1 unit)	$0.00	No EOB	$144.00	Rule 133.307(g)(3)(A-F)	No EOB – MDR will review per Rule 133.307(g)(3)(A-F). The requestor submitted relevant information to support delivery of service. Recommend reimbursement of $48.00 X 3 = $144.00
12-03-02	99213	$48.00 (1 unit)	$0.00	910/049 A	$48.00	96 MFG E/M GR (VI)(B)	A- Preauthorization not required. The requestor submitted relevant information to support delivery of service. Recommend reimbursement of $48.00
12-05-02	99213	$48.00 (1 unit	$0.00	G	$48.00	96 MFG E/M GR (VI)(B)	G- Not global. The requestor submitted relevant information to support delivery of service. Recommend reimbursement of $48.00
12-02-02 to 12-3-02 (2 DOS)	97110	$175.00 (1 unit)	$0.00	910/049 A	$350.00	96 MFG MED GR I (10)(A)	See rationale below. Reimbursement not recommended.
12-11-02	95851	$36.00	$0.00	No EOB	$36.00	Rule 133.307(g)(3) (A-F)	The requestor did not submit relevant information to support delivery of service. Reimbursement not recommended.
TOTAL		$2,907.00	$0.00		$2,907.00		The requestor is entitled to reimbursement in the amount of $1,681.00

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.

This Finding and Decision are hereby issued this 27th day of February 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 06-27-02 through 12-26-02 in this dispute.

This Order is hereby issued this 27th day of February 2004.

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

August 22, 2003

Re: IRO Case # M5-03-2675-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient injured her back on ___ when she bent over to pick up a box of flyers. She was treated with physical therapy, therapeutic exercises, TPIs, medication, x-rays and two MRIs.

Requested Service(s)
FCE, therapeutic procedure 9/16/02, 12/5/02 (CPT code 97110), 12/9/02, 12/11/02 (CPT code 97110), 12/12/02 thru 12/26/02

Decision
I agree with the carrier's decision to deny the requested treatment.

Rationale
The patient had had extensive chiropractic treatment prior to the dates in dispute without documented relief of symptoms or functional improvement. She was examined by one physician on 6/18/02, who stated that examination of the thoracic spine revealed "normal range of motion with no evidence of paraspinous muscle tenderness, spasms or midline tenderness." The physician also noted that, "[t]he lumbar spine shows decreased range of motion with minimum pain." DTRs were normal, and gait testing was normal. The patient was placed at MMI and returned to work. The patient was examined by another physician on 8/27/02 and found to be at MMI. A third physician examined the patient on 8/19/02. He noted decreased lumbar range of motion, muscle spasms and tenderness to palpation, as well as decreased thoracic range of motion, with muscle spasms and tenderness to palpation. These findings indicate that treatment under the treating doctor had failed, and that the patient was getting worse instead of better.
A different physician (from those mentioned above) examined the patient on 6/17/02 and his findings are not consistent with the findings of the treating doctor on that same date. The treating doctor noted several positive orthopedic tests and pain radiating down the patient's left leg, and that x-rays revealed a fracture of the left transverse process at T12. The other examiner noted that the patient was in no apparent distress, SLR test was negative and range of motion was normal. This

might indicate unreliable subjective complaints and possible symptom magnification.
The physician who had examined the patient on 8/19/02, also examined the patient on 11/19/02, after several months of treatment, and noted that there was still decreased range of motion, muscle spasms, tenderness to palpation and trigger points. He further noted that the "patient's progress is less than expected with the present conservative care," and he recommended TPIs. This indicates that treatment was not beneficial.

After an MMI date is reached all further treatment must be reasonable and effective in relieving symptoms or improving function, and that was not the case here. The documentation provided of treatment and chiropractic exercises fails to show measurable or objective improvement.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,