MDR Tracking Number: M5-03-2693-01

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 6-23-03.

The IRO reviewed work hardening program, FCE, office visit w/manipulation, office visit, and medical conference by a physician from 1-10-03 through 2-18-03.

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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 2-13-04, 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:
Where neither party provided an EOB, the review will be according to the 1996 *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
9/25/02 9/26/02 9/27/02 9/30/02 thru 10/4/02 10/7/02 10/8/02 10/10/02 10/11/02 10/14/02 10/17/02	99213	$48.00 x 14 DOS	$0.00	E	$48.00	Rule 133.307(g)(3) (A-F)	TWCC records reveal that the carrier filed a TWCC-21 for indemnity benefits - not medical benefits. Therefore, this review will be according to the 1996 *Medical Fee Guideline.* Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.
10/14/02	97265 97250 97122 97139-TN	$43.00 $43.00 $35.00 $85.00	$0.00	No EOB	$43.00 $43.00 $35.00 DOP		Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
10/15/02	97750 x 12 units	$516.00	$0.00	No EOB	$43.00 ea 15 min	Rule 133.307(g)(3)(A-F)	Relevant information does not support delivery of service per the 1996 *Medical Fee Guideline.* Relevant information was incomplete (modified somatic perception questionnaire had no name and no signature, modified zung index had no name, date, or signature, no test or measurement results or report). No reimbursement recommended.
10/18/02	99213 97265 97250 97122 97110 95851	$48.00 $43.00 $43.00 $35.00 $140.00 $36.00	$0.00	No EOB	$48.00 $43.00 $43.00 $35.00 $35.00 ea 15 min $36.00		Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.
11/21/02	E1399	$50.00	$0.00	No EOB	DOP		
11/25/02	99213 97110 97530	$48.00 $140.00 $140.00	$0.00	No EOB	$48.00 $35.00 ea 15 min $36.00 ea 15 min		
1/6/03	99213	$48.00	$0.00	No EOB	$48.00		
1/23/03 1/24/03 2/3/03 2/6/03 2/7/03 2/10/03 2/11/03 2/12/03 2/13/03	97545WHAP 97546WHAP	$128.00 x 9 DOS $384.00 X 9 DOS	$0.00	No EOB	$64.00 CARF		Relevant information supports delivery of service. Recommend reimbursement of $128.00 x 9 days = $1,152.00 $384.00 x 9 days = $3,456.00 Total $4,608.00.
2/3/03 2/12/03	99361	$53.00 x 2 DOS	$0.00	No EOB	NA		Requestor failed to submit relevant information to support delivery of service.
TOTAL		$6,879.00	$0.00				The requestor is entitled to reimbursement of $4,608.00.

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 relevant information was not submitted to clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

This Decision is hereby issued this 5th day of July 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 Order is applicable for dates of service 1-10-03 through 2-18-03 in this dispute.

This Order is hereby issued this 5th day of July 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION **Amended Letter 07/08/2004**

September 4, 2003
MDR Tracking #: M5-03-2693-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating 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 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 this case.

Clinical History

This patient sustained injuries to his lumbar spine, legs, and hips on ___ when he was pinned by a forklift against pieces of tin. He had multiple pelvic fractures, and an MRI dated 09/16/02 revealed disc bulge at L3-4. His nerve conduction velocity study from 10/29/02 showed dysfunction of the nerve roots at the L5 and S1 levels. He had been seeing a chiropractor for treatment and therapy and then progressed to a work hardening program.

Requested Service(s)

- Work hardening program from 01/10/03 through 02/18/03
- FCE on 01/28/03
- Medical conference by physician on 01/20/03, 01/27/03, 02/17/03
- Office visit on 02/18/03
- Office visit w/manipulation on 02/03/03

Decision

It is determined that the following services were medically necessary to treat this patient:

- Work hardening program from 01/10/03 through 02/18/03
- FCE on 01/28/03
- Medical conference by physician on 01/20/03, 01/27/03, 02/17/03
- Office visit on 02/18/03
- Office visit w/manipulation on 02/03/03

Rationale/Basis for Decision

The patient sustained multiple injuries, which required a four-day hospital stay. After being released, he began a passive and active physical therapy program based upon his condition and diagnostic testing. He progressed into a work hardening program for eight weeks in a CARF (Commission on Accreditation of Rehabilitation Facilities) certified facility. There are sufficient records on each date of service to adequately document and warrant the diagnostic testing and treatment that was rendered. National treatment guidelines allow for an initial phase of passive therapy with a progression into active therapy followed by a work hardening program.

Sincerely,