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

SOAH DOCKET NO. 453-04-3615.M5

MDR Tracking Number: M5-03-2840-01

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 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 7-22-03.

The IRO reviewed application of a modality, ultrasound, electrical stimulation, mechanical traction, massage, office visit, X-rays, hot/cold packs, bronchospasm evaluation, electrocardiogram, physical performance test, therapeutic procedure, and physician team conference rendered from 1-16-02 through 5-1-02, 5-3-02 through 5-24-02, 6-12-02, and 7-1-02.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO has determined that the above listed services from 1-16-02 through 1-28-02 were medically necessary. The IRO agrees with the previous determination that the same services from 1-30-02 through 5-1-02, 5-3-02 through 5-24-02, 6-12-02, and 7-1-02 were not medically necessary. Therefore, the requestor is not entitled to reimbursement 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On September 15, 2003, the Medical Review Division submitted a Notice to the 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$ (Maximum Allowable Reimbursement)	Reference	Rationale
5-1-02	99199	150.51	0.00	No EOB	DOP	96 MFG GI III and CPT descriptor	Relevant information was not submitted to support services rendered. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
5-24-02 5-29-02 6-3-02 6-10-02 6-14-02 6-24-02	97010 97035 97014 97012 97124 97110	14.71x6 17.12x6 20.26x6 23.40x6 23.86x6 62.32x6	0.00	N	11.00 22.00 15.00 20.00 28.00 35.00	96 MFG Med GR I A 10 A;	Office notes dated 6-12-02 and 4-26-02 support all services rendered. The charge for physical medicine treatments shall not exceed the threshold of four. Therefore all codes will be reviewed except 97010 and 97014. See RATIONALE below for code 97110. Recommend reimbursement of $365.88.
6-26-02	99213	58.37	0.00	N	48.00	96 MFG E/M IV C 2; VI B	Relevant information was not submitted to support delivery of service. No reimbursement recommended.
TOTAL		1178.90	0.00				The requestor is entitled to reimbursement of $365.88.

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 has reviewed the matters in light of the Commission requirements for proper documentation.

The Medical Review Division declines to order payment for code 97110 because the daily notes did not clearly indicate activities that would require exclusive one-to-one therapy sessions.

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 1-16-02 through 6-24-02 in this dispute.

This Order is hereby issued this 9th day of January 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

September 16, 2003

NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter

RE: MDR Tracking #: M5-03-2840-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel. This ------ reviewer has been certified for at least level 1 of the TWCC ADL requirements The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 52 year-old male who was 45 years old when he sustained a work related injury on ------. The patient reported that while at work he sustained a repetitive motion injury to his neck, bilateral shoulders, arms, wrists, fingers and back. The patient has undergone several

diagnostic studies that included X-Rays and MRIs. Treatment for this patient's condition has included physical therapy with ultrasound, hot packs, massage, exercises, TENS unit, Biodez and McKenzie exercises. Medication has included Oruvail, Tagament, Darvocet N, as well as Ultram and other medications. The patient also underwent surgery that included arthroscopy of the left shoulder with debridement of rotator cuff and glenoid labrum as well as decompression the left shoulder. Surgery was followed by postoperative rehabilitation.

Requested Services

Application of a modality, ultrasound, electrical stimulation, mechanical traction, massage, office visit, C-Rays, hot or cold packs, bronchospasm evaluation, electrocardiogram, physical performance test, therapeutic procedure, and physician team conference. 1/16/02 through 5/1/02, and 5/3/02 through 5/24/02, 6/12/02 and 7/1/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a 52 year–old male who sustained a work related injury to his neck, bilateral shoulders, arms, wrists, fingers and back. The ------ physician reviewer also noted that the patient sustained an exacerbation to his original work injury and was treated with physical therapy. The ------ physician reviewer explained that the patient was treated extensively with physical therapy in the past, and should be knowledgeable in home based exercise and self directed modalities. The ------ physician reviewer also explained that a short course (6-9 visits) would be reasonable to treat an exacerbation and reinforce a home program. Therefore, the ------ physician consultant concluded that the application of a modality, ultrasound, electrical stimulation, mechanical traction, massage, office visit, C-Rays, hot or cold packs, bronchospasm evaluation, electrocardiogram, physical performance test, therapeutic procedure, and physician team conference from 1/16/02 through 1/28/02 were medically necessary to treat this patient's condition. However, the ------ physician consultant also concluded that the application of a modality, ultrasound, electrical stimulation, mechanical traction, massage, office visit, C-Rays, hot or cold packs, bronchospasm evaluation, electrocardiogram, physical performance test, therapeutic procedure, and physician team conference from 1/30/02 through 5/1/02 and 5/3/02 through 5/24/02, 6/12/02 and 7/1/02 were not medically necessary to treat this patients condition.

Sincerely,

State Appeals Department