MDR Tracking Number: M5-03-2870-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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 07-10-03.

The IRO reviewed office visits, physical therapy sessions, required reports, ROM, muscle testing rendered from 08-15-02 through 11-27-02 that were 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 office visits, physical therapy sessions, required reports, ROM, muscle testing from 08-29-02 through 11-27-02. Consequently, the requestor is not owed a refund of the paid IRO fee.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity office visits, physical therapy sessions, required reports, ROM, muscle testing for 08-15-02, 08-16-02, 08-19-02, 08-21-02, through 08-28-02. 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.

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$ (Maximum Allowable Reimbursement)	Reference	Rationale
08-20-02	97110	$111.00	0.00	No EOB	$35.00	MFG MGR (I)(A)(9)(b)	See rational below
	97250	$46.00	0.00		$43.00	MFG MGR (I)(C)(3	Soap notes do not confirm delivery of service. Reimbursement is not recommended
	97265	$46.00	0.00		$43.00	MFG MGR (I)(C)(3)	

	99080-73	$15.00	0.00		$15.00	Rule 126.5	Copy of status report not submitted for date of service; Unable to confirm delivery of service. Reimbursement is not recommended
	99213	$51.00	0.00		$48.00	MFG E/M GR(IV)(C)(2)	Soap notes do not confirm delivery of service. Reimbursement is not recommended
TOTAL		$111.00					The requestor is not entitled to reimbursement

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 all of the Commission requirements for proper documentation. The MRD declines to order payment because the activities were not identified, duration of each activity was not documented, the requestor did not document that the injury was severe enough to warrant one-to-one therapy, nor did the requestor document the procedure was done in a one-to-one setting.

This Decision is hereby issued this 30th day of January 2004.

Georgina Rodriguez
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 08-15-02 through 11-27-02 in this dispute.

This Order is hereby issued this 30th day of January 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 1/23/04

TWCC Case Number:	
MDR Tracking Number:	M5-03-2870-01
Name of Patient:	
Name of URA/Payer:	Atlantis Healthcare Clinic
Name of Provider: (ER, Hospital, or Other Facility)	Atlantis Healthcare Clinic
Name of Physician: (Treating or Requesting)	Erick Field, DC

August 28, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY
Mr. ___ suffered severe trauma to his left thumb on ___, requiring three (3) surgeries to repair. The first surgery was performed the next day. Additional surgery repair was done 11/13/01. The patient commenced physical therapy at Healthsouth on 11/30/01 for a total of 18 visits. A final surgery to remove an anchor that had been surgically placed was performed 4/2/02. Mr. ___ received post-op care from 4/19/02 – 5/3/02 and returned to work.

On 8/15/02, three (3) months later and almost 10 months post trauma, Mr. ___ sought and received chiropractic care with Dr. Breeding for several weeks.

On 10/29/02 the insurance company, Liberty Mutual Group, approved a work hardening program for 12 visits over the course of three (3) weeks, effective 10/31/02.

REQUESTED SERVICE(S)
Medical necessity of office visits, physical therapy sessions, required reports, ROM, muscle testing 8/15/02 through 11/27/02.

DECISION
Approve service on dates 8/15 - 8/19/02, 8/21 - 8/28/02. No medical necessity for any requested services from 8/29/02 – 11/27/02.

RATIONALE/BASIS FOR DECISION
Mr. ___ sought chiropractic care stating that his thumb pain was persisting with a constant frequency. At the time of exam he stated his pain was at a level of 5/10 scale, and his level usually varied from a 5-7 on a 10 scale. Because chiropractic care had not been tried, a 2-week trial of care was justified according to current treatment guidelines.

On his initial examination with Dr. Breeding, dated 8/15/02, the doctor noted that he would commence an aggressive rehab program while simultaneously putting the patient on light duty at work for 2 weeks. He then stated ‘If we see significant improvement in the patient’s condition, permanent work restrictions will be recommended

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 23rd day of January 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell