MDR Tracking Number: M5-03-2882-01

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 7-11-03.

The IRO reviewed physical therapy, neuromuscular re-education, therapeutic activities, hot/cold packs, electrical stimulation, myofascial release, and office visit rendered from 7-16-02 through 9-6-02 that were denied as unnecessary medical.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. 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 10-21-03, 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
8-02-02	99213	$80.00	0.00	F	$48.00	96 MFG E/M GR VI B	The carrier's EOB shows reimbursement recommended; however, the table of disputed services lists this service as unpaid. Daily note supports delivery of service. Recommend reimbursement of $48.00.
8-15-02	97110 97112 97530 97010 97014	$40.00 $40.00 $40.00 $17.50 $25.00	0.00	D	$35.00 ea 15 min $35.00 ea 15 min $35.00 ea 15 min $11.00 $15.00	96 MFG Med GR I A 10 a and Rule 133.307(g)(3)	Daily note supports delivery of service. Recommend reimbursement of $35.00 + $35.00 + $11.00 + $15.00 = $96.00. See RATIONALE below for

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
							code 97110.
TOTAL		$243.00	0.00				The requestor is entitled to reimbursement of $144.00.

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.

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 8-2-02 and 8-15-02 in this dispute.

This Order is hereby issued this 28th day of January 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

September 27, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-2882-01

___ 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 physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitaiton. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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 ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 55 year-old female who sustained a work related injury on ___. The patient reported that she fell, landing on her left side, but twisted her right side. The patient experienced pain in the right side of her back radiating down the right leg to her knee posteriorly. The patient underwent X-Rays of the lumbar spine and hip. A MRI dated 3/13/02 showed L3-L4 central disc protrusion/extrusion and mild disc bulging and marked disc space narrowing at the L4-L5 and L5-S1 levels. The patient has been treated with physical therapy, epidural steroid injections, oral medications, mechanical traction and electrical stimulation. The patient also received chiropractic manipulation treatment for her back pain from 3/11/02 to 5/1/02.

Requested Services

Physical therapy, neuromuscular reeducation, therapeutic activities, hot/cold packs, electrical stimulation, myofascial release and an office visit from 7/16/02 through 9/6/02.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 55 year-old female who sustained a work related injury to her back on ___. The ___ physician reviewer also noted that the patient has been treated with physical therapy, epidural steroid injections, oral medications and chiropractic manipulations. The ___ physician reviewer indicated that following an epidural injection on 4/4/02 the patient was noted to have improved with greatly diminished pain level. The ___ physician reviewer explained that the patient received a second epidural steroid injection and began physical therapy on 5/14/02. The ___ physician reviewer indicated that the patient started physical therapy on 5/14/02 and that an initial evaluation was performed at that time. However, the ___ physician reviewer noted that there is no subsequent re-evaluation of objective measures or patient's function, range of motion or strength. The ___ physician reviewer also noted that there were subjective notes documenting patient pain or comfort only. The ___ physician reviewer explained that the patient also had a right ankle injury in June documented in a note from 6/12/02. The ___ physician reviewer also explained that this ankle

injury could have affected the patient's participation in therapy. The ___ physician reviewer indicated that without ongoing objective documentation of patient's response to physical therapy, treatment from 7/16/02 through 9/6/02 was not medically necessary to treat this patient's condition. Therefore, the ___ physician consultant conclude that the physical therapy, neuromuscular reeducation, therapeutic activities, hot/cold packs, electrical stimulation, myofascial release and an office visit from 7/16/02 through 9/6/02 were not medically necessary to treat this patient's condition.

Sincerely,