MDR Tracking Number: M5-03-2900-01

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 7-11-03.

The IRO reviewed joint mobilization, myofascial release, manual traction, muscle testing, and therapeutic procedure from 2-11-03 through 4-7-03.

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 9-3-03, 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$ (Max. Allowable Reimbursement)	Reference	Rationale
2-11-03 2-13-03	97110 97110	$140.00 $140.00	$35.00 $35.00	F	$35.00 ea 15 min	133.307(g)(3)(A-F)	See RATIONALE below. No reimbursement recommended.
2-19-03	97122	$ 35.00	$0.00	F	$35.00		Relevant information supports delivery of service. Recommend reimbursement of $35.00
TOTAL		$315.00	$70.00				The requestor is entitled to reimbursement of $35.00.

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 Decision is hereby issued this 30th day of March 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 2-11-03 to 4-7-03 in this dispute.

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

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

August 28, 2003

NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter B

MDR Tracking #: M5-03-2900-01

___ 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 chiropractor on the ___ external review panel. 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 female who sustained a work related injury on ___. The patient reported that while at work she was lifting a tote box full of birdseed over her head into a dumpster. The patient indicated that the box was too heavy and the weight of the box went backwards causing injury to the patient's low back. The patient was initially treated with 2 days of therapy without relief. The patient then underwent an MRI that showed 2mm disc protrusions at the L4/L5 and L5/S1 disc levels. The patient was then treated with active and passive therapy that included joint mobilization, myofascial release, and rehabilitative exercise. The patient then underwent two epidural steroid injections and continued with more physical therapy.

Requested Services

Joint mobilization, myofascial release, manual traction, muscle testing and therapeutic procedure from 2/11/03 through 4/7/03.

Decision

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

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her low back on ___. The ___ chiropractor reviewer also noted that the patient underwent an MRI that showed a 2mm disc protrusion at the L4-L5 and L5-S1 disc levels. The ___ chiropractor reviewer further noted that the patient was treated with active and passive therapy that included joint mobilization, myofascial release, and rehabilitative exercise. The ___ chiropractor reviewer indicated that the patient also underwent two epidural steroid injections followed by more physical therapy. The ___ chiropractor reviewer explained that the treatment this patient received from 2/11/03 through 4/7/03 was medically necessary and appropriate. Therefore, the ___ chiropractor consultant concluded that the joint mobilization, myofascial release, manual traction, muscle testing and therapeutic procedure from 2/11/03 through 4/7/03 were medically necessary to treat this patient's condition.

Sincerely,