MDR Tracking Number: M5-03-2915-01

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 07-11-03. In accordance with Rule 133.307(d)(1) A dispute on a carrier shall be considered timely if it is filed with the division no later then one year after the dates of service in dispute therefore dates of service in dispute for 06-07-02 through 06-24-02 are considered untimely.

The IRO reviewed office visits, therapeutic procedures, myofasical release, joint mobilization, electrical stimulation, and ultrasound rendered from 07-19-02 through 11-11-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for office visits, therapeutic procedures, myofasical release, joint mobilization, electrical stimulation, and ultrasound . 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.

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 September 24, 2003 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
11-18-02	99213	$48.00	$0.00		$48.00	MFG, E/M GR (IV)(C)(2)	Soap notes do not support delivery of service. Reimbursement not recommended
	97110	$140.00	$0.00		$35.00	MFG MGR (I)(A)(9)(b)	See rational below

	97035	$22.00	$0.00		$22.00	MFG MRG (I)(9)(a)(iii)	Soap notes support delivery of service. Recommended reimbursement $22.00
	97265	$43.00	$0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes support delivery of service. Recommended reimbursement $43.00
	97250	$43.00	$0.00		$43.00	MFG, MGR (I)(C)(3)	Soap notes support delivery of service. Recommended reimbursement $43.00
	E1399	$11.00	$0.00		DOP	MFG MGR (I)(A)(9)(b)	Soap notes support delivery of service recommended reimbursement $11.00
12-30-02	99213	$48.00	$0.00		$48.00	MFG, E/M GR (IV)(C)(2)	Soap notes do not support delivery of service. Reimbursement not recommended
	97265	$43.00	$0.00		$43.00	MFG, MGR (I)(C)(3)	Soap notes support delivery of service. Recommended reimbursement $43.00
	97250	$43.00	$0.00		$43.00	MFG, MGR (I)(C)(3)	Soap notes support delivery of service. Recommended reimbursement $43.00
01-06-03	99213	$48.00	$0.00		$48.00	MFG, E/M GR (IV)(C)(2)	Soap notes do not support delivery of service. Reimbursement not recommended
	97110	$140.00	$0.00		$35.00	MFG MGR (I)(A)(9)(b)	See Rational below
	97035	$22.00	$0.00		$22.00	MFG MRG (I)(9)(a)(iii)	Soap notes support delivery of service. Recommended reimbursement $22.00
	97265	$43.00	$0.00		$43.00	MFG, MGR (I)(C)(3)	Soap notes support delivery of service. Recommended reimbursement $43.00
	97250	$43.00	$0.00		$43.00	MFG, MGR (I)(C)(3)	Soap notes support delivery of service. Recommended reimbursement $43.00
TOTAL		$737.00					The requestor is entitled to reimbursement of **$ 313.00**

Rational

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 requestor did not document that the injury was severe enough to warrant one-to-one therapy, each activity and the duration of each was not identified, nor did the requestor document the procedure was done in a one-to-one setting. Reimbursement not recommended

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 07-19-02 through 01-06-03 in this dispute.

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

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

August 22, 2003

Re: MDR #: M5-03-2915-01
IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Certified in Chiropractic Medicine.

Clinical History:
The claimant injured his back while at work on ___. A lumbar MRI dated 12/06/00 revealed evidence of an L4-5 3-4 mm posterior and leftward disk protrusion compressing the left L-4 nerve root, an L5-S1 3.0 mm disk protrusion abutting the traversing S-1 and exiting L-5 nerve root bilaterally, and straightening of the lumbar spinal curvature.

On 03/21/01 the physician noted that the knee flexors were weak (4-5), with positive lumbar orthopedic tests with radicular pain into the left leg, spinous percussion pain at L4-5, tender lumbar paravertebral musculature, tender S-1 joints, and restricted lumbar range of motion.

On 06/28/01 the patient was deemed to have disability from 05/11/01 forward, and, thereafter, he entered a work conditioning/work hardening program. His condition worsened in July 2001 and he

was referred to a neurosurgeon whose clinical impression included low back pain with disk protrusion at L4-5, predominantly on the left side, causing foraminal stenosis, bilateral foraminal stenosis caused by protrusion of a lumbar disk at L5-S1, and lumbar radiculopathy. The neurosurgeon recommended chiropractic care, ESI's, and active rehabilitation. If no improvement in symptomatology, then a CT/myelogram might be necessary.

The patient was reevaluated on 10/31/01 and found not to be at MMI. CT/myelogram was performed on 12/11/01 revealing diskal displacement at L4-5 measuring 3-4 mm, compatible with a broad-based, well-contained herniation. Compression of the L-5 nerve root sleeve was revealed by contrast still noted within the nerve root sleeve. Compression of the left S-1 nerve root sleeve with loss of contrast resulting from a left parasagittal subligamentous herniation measuring 3-4 mm was observed.

Examination on 02/27/02 revealed positive lumbar orthopedic testing, tender paravertebral musculature, and reduced lumbar range of motion and rehabilitative therapy including aquatic therapy, myofascial release and joint mobilization was recommended. The patient showed favorable outcome fro this rehabilitation and ESI's.

The patient was not at MMI on 05/21/02 and re-evaluation by a neurosurgeon for possible surgical intervention was recommended. On 01/13/03 the patient underwent a bilateral L4-5 semi-hemilaminectomy and medial facetectomy with facet undercutting and L-5 nerve root foraminotomies and on 02/12/03 the patient was referred for post-surgical rehabilitation. Favorable results were noted for the post-surgical rehabilitation. However, on 03/05/03 the patient was re-examined and was not at MMI.

Disputed Services:
Office visits, myofascial release, electrical stimulation, therapeutic procedure, joint mobilization, and ultrasound for 07/19/02 through 11/11/02.

Decision:
The reviewer disagrees with the determination of the insurance carrier. The services in question were medically necessary in this case.

Rationale:
The treatment protocol used was within proper guidelines as dictated by the Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters. The office visits, myofascial release, electrical stimulation, therapeutic procedures, joint mobilization, and ultrasound were well documented for the dates of 07/19/02 through 11/11/02 and aided in relieving the effects naturally resulting from the injury and promoted recovery there from.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,