MDR Tracking Number: M5-03-2968-01

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 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 07-16-03. 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 July 2, 2002 through July 11, 2002 are considered untimely.

The IRO reviewed office visits, joint mobilization, therapeutic procedures, electrical stimulation, application of a modality, and durable medical equipment rendered from 07-16-02 through 12-3-02 that were denied based upon “U”.

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, joint mobilization, therapeutic procedures, electrical stimulation, application of a modality, and durable medical equipment. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 09-10-03, 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
07-16-02	97250	$43.00	$0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes support delivery of service. Recommended reimbursement $43.00
	97110	$210.00	$0.00		$35.00	MFG MGR (I)(A)(9)(b)	See Rational below
07-23-02	97110	$140.00	$0.00		$35.00	MFG MGR (I)(A)(9)(b)	See Rational below
	97032	$22.00	$0.00		$22.00	MFG MGR (I)(9)(a)(iii)	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 do not support delivery of service Reimbursement not recommended.
07-25-02	97250	$43.00	$0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes support delivery of service. Recommended reimbursement $43.00
	97110	$70.00	$0.00		$35.00	MFG MGR (I)(A)(9)(b)	See Rational below
08-01-02	97250	$43.00	$0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes support delivery of service. Recommended reimbursement $43.00
08-06-02	97110	$140.00	$0.00		$35.00	MFG MGR (I)(A)(9)(b)	See Rational below
	97250	$43.00	$0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes support delivery of service. Recommended reimbursement $43.00
TOTAL		$840.00					The requestor is entitled to reimbursement of **$** 215.00

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, did not identify each activity and duration of each, nor did the requestor document the procedure was done in a one-to-one setting. Reimbursement not recommended

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 07-16-02 through 08-06-02 in this dispute.

This Decision is hereby issued this 27th day of January 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

September 5, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-03-2968-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was injured when he was lifting some 55 gallon drums and one fell on top of him, causing him to twist and fall. He had pain in his ribs on the right side as well as thoracic and lumbar pain. After attempting to work for the next several days, the patient presented to ___, DC 4 days after the injury to seek care. MRI of the lumbar spine indicated a lumbar disc herniation at L4/5. EMG to the lower extremities indicated that there was not a radiculopathy associated with the discopathy. A required Medical Examination was performed by ___ on December 19, 2001 that found the patient to not be at MMI. ___ was treated with chiropractic as well as passive and active therapies for the duration of his care with the treating clinic. This is to include a work hardening program. A statement letter by the requestor's attorney indicated that after the work hardening program, the patient was continued into an active treatment program of therapeutic activities "twice weekly to maintain the gains that ___ had achieved through the work hardening. He was participating in therapeutic activities similar to those in Work Hardening, but rather than 5 days weekly, participation was reduced to twice weekly to determine if he would suffer any

deterioration prior to returning to work full time. He was also provided limited passive modalities to treat both the residual chronic pain and the pain caused by increased activity."

DISPUTED SERVICES

Under dispute is the medical necessity of office visits, joint mobilization, therapeutic procedures, electrical stimulation, application of a modality, and durable medical equipment.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The active and passive modalities which were rendered during this dispute period, exclusive of those deemed not to be under the review of this case, were not medically necessary. There is not only no indication of progress on the case, there is also no indication of there even being a problem that would require such extensive care. The attorney's letter in the record indicates that the care was used to prevent a problem from actually occurring, as opposed to treating a condition that required the doctor's attention. Considering that a work hardening program had been completed there is no indication that continuing an active treatment program for several weeks afterward and continuing to keep the patient off work for an injury that *may* occur if the patient is allowed to return to work. This seems to be a maintenance program more than a rehabilitation program and would not be considered medically necessary at this point in the patient's treatment program.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,