MDR Tracking Number: M5-03-3004-01

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 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 07-18-03.

The IRO reviewed hot or cold pack therapy, therapeutic procedures, office visits with manipulation, radiological exam and prolonged evaluation/management rendered from 11-05-02 through 01-27-03 that was denied based upon "V".

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.

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 10-09-03, 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$	Reference	Rationale
11-22-02 through 1-20-03 (4 DOS)	99080-73	$60.00 ($15.00 per unit X 4 DOS)	$0.00	O	$15.00	Rule 133.106(f)	Requestor submitted relevant information to support delivery of service for DOS 11-22-02, 12-9-02 and 1-20-03. Requestor did not submit relevant information to support delivery of service for DOS 1-6-03. Reimbursement recommended in amount of $15.00 X 3 DOS = $45.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
12-4-02	99213	$48.00 (1 unit)	$0.00	No EOB	$48.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
12-4-02	97110	$70.00 (2 units)	$0.00	No EOB	$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
TOTAL		$118.00	$0.00				The requestor is entitled to reimbursement in the amount of $45.00

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 12th day of April 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

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 11-05-02 through 01-27-03 in this dispute.

This Order is hereby issued this 12th day of April 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dlh

NOTICE OF INDEPENDENT REVIEW DECISION - REVISION

Date: March 31, 2004

RE: MDR Tracking #: M5-03-3004-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer and has ADL certification. The Chiropractic physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History
According to the supplied documentation, it appears that the claimant injured his left ankle when he fell at work on ___. The claimant was taken to ___, who diagnosed the claimant with a bimalleolar fracture/dislocation. The claimant underwent surgery and began physical therapy at ___. The claimant stopped care around 10/30/2002 and changed treating doctors to ___. ___ began chiropractic therapy on the claimant. ___ treated the claimant between 11/05/2003 – 01/27/2003 with passive and active modalities. The claimant was reported to be at maximum medical improvement on 01/20/2003, with a whole person impairment of 5%. The documentation ends here.

Requested Service(s)
Please review and address the medical necessity of the outpatient services including office visits with manipulation, radiological exam, prolonged evaluation/management, hot or cold packs, and therapeutic procedures rendered between 11/5/2002 through 01/27/2003.

Decision
I disagree with the insurance company and agree with the treating doctor that the services rendered between 11/21/2002 – 12/16/2002 were medically necessary including radiological exams, hot or cold packs and therapeutic procedures. I also feel that the office visits on the following days were necessary with the exclusion of the manipulation: 11/05/2002 (99205 maximum), 11/06/2002 (99213 maximum), 12/04/2002 (99213 maximum), 01/06/2003 (99213 maximum) and 1/27/2003 (99213 maximum). I agree with the insurance company that the remainder of office visits with manipulation billed, prolonged evaluation/management and all of the therapy rendered between 12/17/2002 – 01/27/2003 was not medically necessary excluding the office visits listed above.

Rationale/Basis for Decision

According to the supplied documentation, the therapy rendered for the initial 8 weeks would be considered medically necessary for the injury sustained. The therapy between 10/21/2002-12/16/2002 is reasonable and deemed medically necessary for the injury the claimant sustained. The initial care was rendered at a physical therapy facility and then continued at the treating chiropractor's facility. The therapy rendered during this time is a typical protocol for rehabilitation of the claimant's fracture. The continual therapy rendered during this time is necessary, while daily office visits would not be necessary to monitor the claimant's condition. There is no supported documentation or rationale for any manipulation of a joint that had recently sustained a fracture. Monthly office visits would be adequate for this particular case. The therapy beyond the 12/17/2002 was not supported in the documentation supplied nor is supported by current medical and chiropractic standards of care. The notes from the surgeon in this file reveal that the claimant had full range of motion in his ankle with occasional pain. This follow-up visits would also justify only minimal extension in care with a gradual change to the claimant beginning a home exercise program.