

MDR Tracking Number: M5-03-3036-01

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 July 16, 2003. Per Rule 133.308 (e)(1) dates of service rendered on 7/1/02 through 7/15/02 were filed untimely and are therefore, not eligible for review.

The IRO reviewed therapeutic exercises, office visits w/manipulations, electrical stimulation, therapeutic activities, myofascial release and joint mobilization rendered on 7/17/02 through 9/6/02, 9/9/02, 9/11/02 through 9/13/02, 9/16/02, 9/18/02 through 9/20/02 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 October 20, 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.

Both the requestor and the respondent failed to submit copies of EOBs. The dates of service in dispute will be reviewed according to the Medical Fee Guideline.

The following table identifies the disputed services and Medical Review Division's rationale:

<b>DOS</b>	<b>CPT CODE</b>	<b>Billed</b>	<b>Paid</b>	<b>EOB Denial Code</b>	<b>MARS</b>	<b>Reference</b>	<b>Rationale</b>
9/9/02	97032	\$45.00	\$0.00	No EOB	\$22.00	<u>MFG, Medicine Ground Rule</u> ((I)(A)(9)(a)(iii), (I)(A)(10)(a))	Review of the daily SOAP note dated 9/9/02, does not support delivery of service. Reimbursement is therefore not recommended.
9/16/02	97110 x 8 units	\$280.00	\$0.00	No EOB	\$280.00	<u>MFG, Medicine Ground Rule</u> (I)(A)(9)(b), (I)(A)(10)(a) & (I)(A)(11)(a))	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

						<p>413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.</p> <p>The MRD declines to order payment because the SOAP note did not indicate whether the doctor was conducting exclusively one-to-one sessions with the claimant, the notes did not clearly indicate activities that would require a one-on-one therapy session, the notes did not indicate the type of activity/therapy, the notes did not reflect the need for one-on-one supervision and there was no statement of the claimants medical condition or symptoms that would mandate one-on-one supervision for an entire session or over an entire course of treatment.</p>
TOTAL		\$325.00	\$0.00		\$302.00	The requestor, is therefore, not

							entitled to reimbursement.
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This Decision is hereby issued this 30<sup>th</sup> day of January 2004.

Margaret Q. Ojeda  
 Medical Dispute Resolution Officer  
 Medical Review Division  
 MQO/mqo

**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 7/17/02 through 9/6/02, 9/9/02, 9/11/02 through 9/13/02, 9/16/02, 9/18/02 through 9/20/02 in this dispute.

This Order is hereby issued this 30<sup>th</sup> day of January 2004.

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

October 20, 2003

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 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 reviewer is on the TWCC Approved Doctor List (ADL). 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

This patient was injured on his job when he slipped and fell on \_\_\_ and fractured the distal right tibia and proximal right fibula. He also suffered pain to the thoracic and lumbar spines. He underwent surgery to the right leg 2 days later which included an open reduction/internal fixation with an intramedullary rod of the tibia. The patient later was referred for rehabilitation to \_\_\_, who began with passive treatment and progressed over about 3 weeks to active care in late March, of 2002. The patient demonstrated normal progress for his injury, but reported a locking of his knee, which would cause him to fall. MRI was ordered due to the possibility of meniscal damage. The MRI demonstrated degeneration of the medial meniscus posterior horn but no evidence of a ligamentous tear. He was returned to work on May 20, 2002 on restricted duty and continued rehabilitation for up to 3 times per week. The patient continued to have difficulty with the locking of the knee and he fell multiple times. He was recommended for arthroscopic surgery, which took place on August 1, 2002. Damage was reported to the medial femoral condyle and there was reported to be extensive scar tissue. The femur was treated with debridement and there was a partial synovectomy performed as well. He again was treated with progressive PT, starting with passive therapy and moving into active treatment. He was released by \_\_\_ to return to work on September 23, 2002.

There was a peer review performed by \_\_\_, which was performed before the service dates and surgical procedure in question. He recommended no further care.

#### DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic procedure, office visits with manipulation, electrical stimulation, therapeutic activities, myofascial release and joint mobilization.

#### DECISION

The reviewer disagrees with the prior adverse determination.

#### BASIS FOR THE DECISION

One must consider that the patient had a mechanical dysfunction in the knee which went undiagnosed in spite of the efforts of \_\_\_ to discover the malfunction. The rehabilitation which was utilized on this patient was significant, but it was also necessary to get this patient back to work. We see from the records that the patient, while responding significantly to the care, was also not able to perform his duties due to the persistent failure of his knee to perform adequately. Indeed, a second surgical procedure was performed to allow his knee to flex and extend adequately. The rehabilitation that was performed was well within the established guidelines for a case such as this, considering the patient's response and the complications of the case. As a result, the care was reasonable for this particular case.

\_\_\_ 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 \_\_\_, Inc, dba \_\_\_, 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,