

MDR Tracking Number: M5-03-3054-01

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 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 7-24-03.

The IRO reviewed therapeutic exercises and activities, electrical stimulation, hot/cold packs, and office visits from 7-24-02 through 8-21-02.

The Medical Review Division has reviewed the enclosed IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. The IRO concluded that the therapeutic exercises and activities and office visits from 7-24-02 to 8-21-02 were medically necessary. The IRO concluded that the hot/cold packs and electrical stimulation from 7-24-02 to 8-21-02 were not medically necessary. Therefore, upon receipt of this Order and per Rule §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund** the requestor **\$650.00** 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 9-12-03, the Medical Review Division submitted a Notice to the 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	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
8-16-02 8-21-02	97110 x 2 97014	\$175.00 x2 \$15.00	\$0.00	No EOB	\$35.00 ea 15 min \$15.00	Rule 133.307(g)(3) (A-F)	97014. Daily note supports delivery of service. Recommend reimbursement of \$15.00. 97110. See RATIONALE below.
TOTAL		\$315.00	0.00				The requestor is entitled to reimbursement of \$15.00.

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.

The above Findings and Decision are hereby issued this 27th day of February 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 7-24-02 through 8-21-02 in this dispute.

This Order is hereby issued this 27th day of February 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 2/20/04

MDR Tracking Number: M5-03-3054-01

September 8, 2003

An independent review of the above-referenced case has been completed by a doctor board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

37 year-old female who on ___ apparently suffered 'repetitive cumulative trauma type injury for assembling computer parts.' Thereafter she received weeks of rehabilitation and then nine months of chiropractic care for essentially multiple soft tissue injuries purportedly secondary to assembly line work.

An electro diagnostic exam was reported positive for right median neuropathy at the wrist. MRI showed supraspinatus tendonopathy and arthritic changes at the AC joint.

She reached MMI on 7/15/02 for the dislocation of her shoulder and tendonitis of the hand.

REQUESTED SERVICE(S)

Therapeutic exercises, electrical stimulation, hot/cold packs, office visits, therapeutic activities for 7/24/02 through 8/14/02, 8/16/02 – cpt codes 97010, 97530 only. 8/19/02, 8/21/02 - cpt codes 97014, 97010, 97530 only

DECISION

Partial approval. Approve therapeutic activities, approve therapeutic exercises and office visits for dates. Deny hot/cold packs and modalities (CPT code 97014).

RATIONALE/BASIS FOR DECISION

Referencing the standard, as described by D.C. Weber, MD in Randall L. Braddon Physical Medicine and Rehabilitation, 1996, Therapeutic Modalities including hot, cold, electricity are considered adjunctive treatments rather than primary curative interventions. On the disputed dates, this patient could have clearly performed her own therapeutic modalities and furthermore, they were likely providing little benefit in this chronic soft tissue injury.

On the other hand continuing therapeutic exercise and activities is appropriate, with the goal of establishing a home program.