

MDR Tracking Number: M5-03-3081-01

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 07-28-03.

The IRO reviewed office visits, joint mobilization, myofascial release, manual traction, special report, muscle testing, MRI spine, range of motion measurements, therapeutic procedures, temperature gradient studies, work hardening, medical conference and functional capacity evaluations on dates of service 09-26-02 through 10-09-02, 10-11-02, 10-18-02 through 11-11-02, 11-18-02, 11-19-02, 11-21-02 and 11-29-02 through 02-28-03 that were denied based upon “U” and “V”.

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(r)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
9-26-02 through 1-20-03 (24 DOS)	99213	\$1,152.00 (1 unit @ \$48.00 X 24 DOS)	\$0.00	U,V	\$48.00	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$48.00 X 24 DOS = \$1,152.00
9-26-02 through 11-8-02 (14 DOS)	97265	\$602.00 (1 unit @ \$43.00 X 14 DOS)	\$0.00	U	\$43.00	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$43.00 X 14 DOS = \$602.00
9-26-02 through 11-8-02 (14 DOS)	97250	\$602.00 (1 unit @ \$43.00 X 14 DOS)	\$0.00	U	\$43.00	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$43.00 X 14 DOS = \$602.00
9-26-02 through 11-8-02 (15 DOS)	97122	\$525.00 (1 unit @ \$35.00 X 15 DOS)	\$0.00	U	\$35.00	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$35.00 X 16 DOS = \$525.00
9-26-02 through 12-12-02 (20 DOS)	97110	\$2,800.00 (4 units @ \$140.00 X 20 DOS)	\$0.00	U	\$35.00	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$140.00 X 20 DOS = \$2,800.00
10-2-02	99080-73	\$15.00 (1 unit)	\$0.00	U	\$15.00	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$15.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
10-4-02 11-6-02 11-21-02 (3 DOS)	97750-MT	\$301.00 (3 units @ \$129.00 on 10-4-02 & 11-21-02, 1 unit @ \$43.00 on 11-6-02, 7 units total)	\$0.00	U	\$43.00	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$43.00 X 7 units = \$301.00
10-4-02	93740-WP	\$672.00 (8 units)	\$0.00	U	\$84.00	IRO DECISION	IRO determined services to not be medically necessary. No reimbursement recommended.
10-8-02 and 12-2-02 (2 DOS)	95851	\$216.00 (3 units @ \$108.00 X 2 DOS)	\$0.00	U	\$36.00	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$108.00 X 2 DOS = \$216.00
11-11-02	97750	\$688.00 (16 units)	\$0.00	U	\$43.00	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$43.00 X 16 units = \$688.00
12-11-02 and 1-22-03 (2 DOS)	97750-FC	\$700.00 (\$500.00 12-11-02 & \$200.00 on 1-22-03)	\$0.00	U	\$500.00 \$200.00	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$700.00
12-2-02 through 12-12-02 (5 DOS)	97530	\$700.00 (4 units @ \$140.00 X 5 DOS)	\$0.00	U	\$35.00	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$140.00 X 5 DOS = \$700.00
12-17-02 through 1-23-03 (8 DOS)	97545-WH-AP	\$1,024.00 (2 units @ \$128.00 X 8 DOS)	\$0.00	U,V	\$64.00 (CARF provider)	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$128.00 X 8 DOS = \$1,024.00
12-17-02 through 1-23-03 (8 DOS)	97546-WH-AP	\$2,944.00 (6 units @ \$384.00 X 7 DOS, 4 units @ \$256.00 X 1 DOS)	\$0.00	U,V	\$64.00 (CARF provider)	IRO DECISION	IRO determined services to be medically necessary. Reimbursement recommended in the amount of \$64.00 X 46 units = \$2,944.00
11-29-02	72147-27-22	\$756.00 (1 unit)	\$0.00	U	\$756.00	IRO DECISION	IRO determined services to not be medically necessary. No reimbursement recommended.
11-29-02	72148-27-22	\$756.00 (1 unit)	\$0.00	U	\$756.00	IRO DECISION	IRO determined services to not be medically necessary. No reimbursement recommended.
1-24-03 through 2-13-03 (14 DOS)	97545-WH-AP	\$1,792.00 (2 units @ \$128.00 X 14 DOS)	\$0.00	U,V	\$64.00 (CARF provider)	IRO DECISION	IRO determined services to not be medically necessary. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
1-24-03 through 2-13-03 (14 DOS)	97546-WH-AP	\$5,376.00 (6 units @ \$384.00 X 14 DOS)	\$0.00	U,V	\$64.00 (CARF provider)	IRO DECISION	IRO determined services to not be medically necessary. No reimbursement recommended.
1-27-03 and 2-3-03 (2 DOS)	99361	\$106.00 (1 unit @ \$53.00 X 2 DOS)	\$0.00	U,V	\$53.00	IRO DECISION	IRO determined services to not be medically necessary. No reimbursement recommended.
1-29-03	99211	\$18.00 (1 unit)	\$0.00	V	\$18.00	IRO DECISION	IRO determined services to not be medically necessary. No reimbursement recommended.
1-31-03 2-20-03 2-28-03 (3 DOS)	99213	\$144.00 (1 unit @ \$48.00 X 3 DOS)	\$0.00	U,V	\$48.00	IRO DECISION	IRO determined services to not be medically necessary. No reimbursement recommended.
TOTAL		\$21,799.00					The requestor is entitled to reimbursement of \$12,269.00

The IRO concluded that office visits, joint mobilization, myofascial release, manual traction, special report, muscle testing, range of motion measurements, therapeutic procedure, work hardening, medical conference and functional capacity evaluations rendered from 09-26-02 through 01-23-03 **were** medically necessary. The IRO concluded that office visits with manipulation, temperature gradient studies, MRI of the spine and any treatment after 01-23-03 **was not** medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees (**\$12,269.00**). 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.

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 10-09-2003, 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:

Services listed below with denial codes E and E,R are being reviewed as fee issues. The compensability issue had been resolved by a contested case hearing held on 07-03-03. The contested case hearing decision of 07-03-03 was not appealed.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
9-23-02	99204	\$106.00 (1 unit)	\$0.00	E	\$106.00	Rule 133.307 (g)(3)(A-F)	Entitlement issue resolved by CCH. Respondent raised no other reasons for denying reimbursement. Reimbursement recommended in the amount of \$106.00
9-23-02	72052-WP	\$132.00 (1 unit)	\$0.00	E	\$132.00	Rule 133.307 (g)(3)(A-F)	Entitlement issue resolved by CCH. Respondent raised no other reasons for denying reimbursement. Reimbursement recommended in the amount of \$132.00
9-23-02	72114-WP	\$120.00 (1 unit)	\$0.00	E	\$120.00	Rule 133.307 (g)(3)(A-F)	Entitlement issue resolved by CCH. Respondent raised no other reasons for denying reimbursement. Reimbursement recommended in the amount of \$120.00
9-23-02	73030-WP	\$60.00 (1 unit)	\$0.00	E	\$60.00	Rule 133.307 (g)(3)(A-F)	Entitlement issue resolved by CCH. Respondent raised no other reasons for denying reimbursement. Reimbursement recommended in the amount of \$60.00
9-24-02 through 11-27-02 (10 DOS)	99213	\$480.00 (1 unit @ \$48.00 X 10 DOS)	\$0.00	E, R	\$48.00	Rule 133.307 (g)(3)(A-F)	Entitlement issue resolved by CCH. Respondent raised no other reasons for denying reimbursement. Reimbursement recommended in the amount of \$48.00 X 10 DOS = \$480.00
9-24-02 through 11-19-02 (6 DOS)	97265	\$258.00 (1 unit @ \$43.00 X 6 DOS)	\$0.00	E	\$43.00	Rule 133.307 (g)(3)(A-F)	Entitlement issue resolved by CCH. Respondent raised no other reasons for denying reimbursement. Reimbursement recommended in the amount of \$43.00 X 6 DOS = \$258.00
9-24-02 through 11-19-02 (6 DOS)	97250	\$258.00 (1 unit @ \$43.00 X 6 DOS)	\$0.00	E	\$43.00	Rule 133.307 (g)(3)(A-F)	Entitlement issue resolved by CCH. Respondent raised no other reasons for denying reimbursement. Reimbursement recommended in the amount of \$43.00 X 6 DOS = \$258.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
9-24-02 through 11-19-02 (5 DOS)	97122	\$175.00 (1 unit @ \$35.00 X 5 DOS)	\$0.00	E	\$35.00	Rule 133.307 (g)(3)(A-F)	Entitlement issue resolved by CCH. Respondent raised no other reasons for denying reimbursement. Reimbursement recommended in the amount of \$35.00 X 5 DOS = \$175.00
9-24-02 through 11-27-02 (9 DOS)	97110	\$1,260.00 (4 units @ \$140.00 X 9 DOS)	\$0.00	E, R	\$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
10-17-02 through 11-14-02 (4 DOS)	97110	\$560.00 (4 units @ \$140.00 X 4 DOS)	\$0.00	NO EOB	\$35.00	Rule 133.307 (e)(2)(b)	There is no convincing evidence of the carrier's receipt from the provider requesting EOB's. No reimbursement recommended.
10-16-02	97750	\$516.00 (12 units)	\$0.00	E	\$43.00	Rule 133.307 (g)(3)(A-F)	Entitlement issue resolved by CCH decision. Respondent raised no other reasons for denying reimbursement. Reimbursement recommended in the amount of \$43.00 X 12 units = \$516.00
10-17-02 through 11-14-02 (4 DOS)	99213	\$192.00 (1 unit @ \$48.00 X 4 DOS)	\$0.00	NO EOB	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted convincing evidence to support delivery of service. Reimbursement recommended in the amount of \$48.00 X 4 DOS = \$192.00
10-17-02 through 11-14-02 (4 DOS)	97265	\$172.00 (1 unit @ \$43.00 X 4 DOS)	\$0.00	NO EOB	\$43.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted convincing evidence to support delivery of service. Reimbursement recommended in the amount of \$43.00 X 4 DOS = \$172.00
10-17-02 through 11-14-02 (4 DOS)	97250	\$172.00 (1 unit @ \$43.00 X 4 DOS)	\$0.00	NO EOB	\$43.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted convincing evidence to support delivery of service. Reimbursement recommended in the amount of \$43.00 X 4 DOS = \$172.00
11-14-02	95851	\$108.00 (3 units)	\$0.00	NO EOB	\$36.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted convincing evidence to support delivery of service. Reimbursement recommended in the amount of \$36.00 X 3 units = \$108.00
10-17-02 through 11-14-02 (4 DOS)	97122	\$140.00 (1 unit @ \$35.00 X 4 DOS)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted convincing evidence to support delivery of service. Reimbursement recommended in the amount of \$35.00 X 4 DOS = \$140.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
11-19-02	93740-WP	\$336.00 (4 units)	\$0.00	E	\$84.00	Rule 133.307 (g)(3)(A-F)	Entitlement issue resolved by CCH decision. IC raised no other reasons for denying reimbursement. Reimbursement recommended in the amount of (single reimbursement per CPT descriptor) = \$84.00
11-20-02 through 11-27-02 (4 DOS)	97530	\$560.00 (4 units @ \$140.00 X 4 DOS)	\$0.00	E, R	\$35.00	Rule 133.307 (g)(3)(A-F)	Entitlement issue resolved by CCH decision. IC raised no other reasons for denying reimbursement. Reimbursement recommended in the amount of \$140.00 X 4 DOS = \$560.00
TOTAL		\$5,605.00	\$0.00				Requestor is entitled to additional reimbursement in the amount of \$3,565.00

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 Findings and Decision is hereby issued this 17th day of August 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

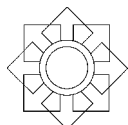
ORDER

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 medically necessary services as well as the fee disputes adjudicated in this decision. 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 09-23-02 through 11-29-02 in this dispute.

This Order is hereby issued this 17th day of August 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO Decision



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

October 3, 2003

**AMENDED LETTER. See Requested Services
Amended Letter 07/13/04**

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-03-3081-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional 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 TMF 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

This patient was injured on ____ while working on a pipeline tunnel under an interstate. He was pushing approximately 700 pounds of dirt and rocks in a cart when it jumped the track and he fell, hurting his low back, neck, and right shoulder. A lumbar MRI dated 11/29/02 revealed a disc herniation impinging on the thecal sac and a cervical MRI, same day, revealed a herniation at C3-4 without impingement.

Requested Service(s)

Office visits, joint mobilization, myofascial release, manual traction, special report, muscle testing, MRI spine, range of motion measurements, therapeutic procedure, temperature gradient studies, work hardening, medical conference, and functional capacity evaluations on dates 09/26/02 through 10/09/02, 10/11/02, 10/18/02 through 11/11/02 (which includes 11/10/02), 11/18/02, 11/21/02, and 11/29/02 through 02/28/03.

Decision

It is determined that the services rendered from 09/26/02 through 01/23/03 which include the initial two hours of work hardening, subsequent work hardening, team conference, functional testing, therapeutic exercises, manual traction, myofascial release, joint mobilization, special reports, office visits, and muscle testing are medically necessary.

It is determined that the office visit with manipulation, temperature gradient studies, the MRI of the spine and any treatment after 01/23/03 are not medically necessary.

Rationale/Basis for Decision

The provider showed appropriate management of this patient's medical condition through conservative unidisciplinary and upper level multidisciplinary therapeutics that include work hardening. It was appropriate for the patient to undergo Physical Therapy services until 12/11/02 given the complexity of his injuries. It was apparent from review of the medical record that the patient needed to be progressed into upper level therapeutics like work hardening given the degree of psychosocial dysfunction and functional limitations documented as early as 10/15/02. The fact that the patient's claim was denied for nearly a year may have explained some of the plateaus experienced in the course of caring for this patient. The provider's decision to continue to implement upper level therapeutics beyond the MMI date assigned by James Kirk Knott MD on 01/23/03 is not supported by the medical record.

It is clear that this patient was a candidate for unidisciplinary conservative therapeutics. It is clear that this patient was a candidate for upper level therapeutics that included work hardening. The provider has factually supported his treatment progression with ROM studies, functional questionnaires, and Functional Capacity Evaluations (FCE).

MR imaging over the cervical/lumbar spine has revealed discal pathology. Provider's request to review the denial of MR imaging is unclear from reviewing the medical record. The medical record does warrant the application of MR imaging to the cervical /lumbar spine but not the thoracic spine and/or sacrum.

This patient is no longer a candidate for any unidisciplinary, passive therapies that include Chiropractic and Physical Therapy. This patient must be educated in the importance of active patient-driven therapeutics and is an excellent candidate for the implementation of a home rehabilitation program with periodic clinical monitoring for activity instruction and progression.

It is determined that the services rendered from 09/26/02 through 01/23/03 which include the initial two hours of work hardening, subsequent work hardening, team conference, functional testing, therapeutic exercises, manual traction, myofascial release, joint mobilization, special reports, office visits and muscle testing are medically necessary.

It is determined that the office visit with manipulation, temperature gradient studies, MRI of the spine and any treatment after 01/23/03 are not medically necessary.

Sincerely,

A handwritten signature in black ink, appearing to read "Gordon B. Strom, Jr.", written in a cursive style.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm