

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-04-5234.M5

MDR Tracking Number: M5-03-3156-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 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 8-4-03.

The IRO reviewed electrical stimulation, office visits w/manipulations, myofascial release, joint mobilization, therapeutic procedure, and physical performance test, and special reports from 7-1-02 through 10-10-02.

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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 2-17-04, 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\$ (Max. Allowable Reimbursement)	Reference	Rationale
7-1-02	99213MP 97250 97265 97110	\$48.00 \$43.00 \$43.00 \$35.00	\$0.00	D	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min	Rule 133.307(g)(3) (A-F)	Relevant information did not support delivery of services. No reimbursement recommended.
7-18-02	99213MP 97250 97265 97110	\$48.00 \$43.00 \$43.00 \$35.00	\$0.00	D	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$48.00, \$43.00, \$43.00 = \$134.00. Code 97110. See RATIONALE below
7-22-02	99213MP 97250	\$48.00 \$43.00	\$0.00	D	\$48.00 \$43.00	Rule 133.307(g)(3)	Relevant information supports delivery of service.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
	97265 97110	\$43.00 \$35.00			\$43.00 \$35.00 ea 15 min	(A-F)	Recommend reimbursement of \$48.00, \$43.00, \$43.00 = \$134.00. Code 97110. See RATIONALE below
7-25-02	99213MP 97250 97265 97110	\$48.00 \$43.00 \$43.00 \$35.00	\$0.00	D	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$48.00, \$43.00, \$43.00 = \$134.00. Code 97110. See RATIONALE below
7-29-02	99213MP 97250 97265 97110 97014	\$48.00 \$43.00 \$43.00 \$35.00 \$15.00	\$0.00	No EOB	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min \$15.00	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$48.00, \$43.00, \$43.00, \$15.00 = \$149.00. Code 97110. See RATIONALE below
8-1-02	99213MP 97250 97265 97110 97014	\$48.00 \$43.00 \$43.00 \$35.00 \$15.00	\$0.00	No EOB	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min \$15.00	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$48.00, \$43.00, \$43.00, \$15.00 = \$149.00. Code 97110. See RATIONALE below
8-21-02	99213MP 97250 97265 97110 97014	\$48.00 \$43.00 \$43.00 \$35.00 \$15.00	\$0.00	No EOB	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min \$15.00	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$48.00, \$43.00, \$43.00, \$15.00 = \$149.00. Code 97110. See RATIONALE below
8-22-02	99213MP 97250 97265 97110 97014	\$48.00 \$43.00 \$43.00 \$35.00 \$15.00	\$0.00	No EOB	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min \$15.00	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$48.00, \$43.00, \$43.00, \$15.00 = \$149.00. Code 97110. See RATIONALE below
8-28-02	99213MP 97250 97265 97110 97014	\$48.00 \$43.00 \$43.00 \$35.00 \$15.00	\$0.00	No EOB	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min \$15.00	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$48.00, \$43.00, \$43.00, \$15.00 = \$149.00.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
							Code 97110. See RATIONALE below
8-29-02	99213MP 97250 97265 97110 97014	\$48.00 \$43.00 \$43.00 \$35.00 \$15.00	\$0.00	No EOB	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min \$15.00	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$48.00, \$43.00, \$43.00, \$15.00 = \$149.00. Code 97110. See RATIONALE below
9-9-02	99213MP 97250 97265 97110	\$48.00 \$43.00 \$43.00 \$35.00	\$0.00	D	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min	Rule 133.307(g)(3) (A-F)	Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.
9-16-02	99213MP 97250 97265 97110 97014	\$48.00 \$43.00 \$43.00 \$35.00 \$15.00	\$0.00	No EOB	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min \$15.00	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$48.00, \$43.00, \$43.00, \$15.00 = \$149.00. Code 97110. See RATIONALE below
9-19-02	99213MP 97250 97265 97110	\$48.00 \$43.00 \$43.00 \$35.00	\$0.00	D	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$48.00, \$43.00, \$43.00 = \$134.00. Code 97110. See RATIONALE below
9-23-02	99213MP 97250 97265 97110	\$48.00 \$43.00 \$43.00 \$35.00	\$0.00	D	\$48.00 \$43.00 \$43.00 \$35.00 ea 15 min	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$48.00, \$43.00, \$43.00 = \$134.00. Code 97110. See RATIONALE below
TOTAL		\$2,471.00	\$0.00				The requestor is entitled to reimbursement of \$1,713.00.

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 23rd day of March 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 7-1-02 through 10-10-02 in this dispute.

This Order is hereby issued this 23rd day of March 2004.

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

February 11, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-3156-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on _____. The patient reported that while at work he injured his back when he was lifting boxes and loading them onto a conveyor belt. A MRI of the lumbar spine dated 2/20/02 showed minimal annular bulges at the L1-L2, L2-L3, L4-L5 and L5-S1 without evidence of disc herniation, and mild hypertrophic disease at the L4-L5 level. The patient underwent a NCV study on 2/1/02 that indicated prolonged bilateral dermatosensory latency of the S1 level suggestive of nerve root dysfunction or sensory pathway at bilateral S1 level. Treatment for this patient's condition has included joint mobilization, manual traction, myofascial therapy, Russian electrical stimulation, axial traction, and active rehabilitation.

Requested Services

Electrical stimulation, office visits with manipulations, myofascial release, joint mobilization, therapeutic procedures, physical performance test and special report from 7/1/02 through 10/10/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The _____ chiropractor reviewer noted that this case concerns a male who sustained a work related to his back on _____. The _____ chiropractor reviewer also noted that an MRI dated 2/20/02 showed minimal annular bulges at the L1-L2, L2-L3, L4-L5 and L5-S1 level without evidence of disc herniation, and mild hypertrophic disease at the L4-L5 level. The _____ chiropractor reviewer further noted that treatment for this patient's condition has included joint mobilization, manual traction, myofascial therapy, Russian electrical stimulation, axial traction, and active rehabilitation. The _____ chiropractor reviewer explained that the patient responded to the treatment rendered despite the diagnoses and the exacerbation that he experienced. Therefore, the _____ physician consultant concluded that the Electrical stimulation, office visits with manipulations, myofascial release, joint mobilization, therapeutic procedures, physical performance test and special report from 7/1/02 through 10/10/02 were medically necessary to treat this patient's condition.

Sincerely,