**THIS MDR TRACKING NO. WAS WITHDRAWN.**
**THE AMENDED MDR TRACKING NO. IS M5-04-2369-01**

MDR Tracking Number: M5-03-3252-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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 August 12, 2003.

The IRO reviewed electrical stimulation, myofascial release, therapeutic procedure rendered on 10/7/02 through 11/1/02 denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Consequently, the requestor is not owed a refund of the paid IRO fee.

The electrical stimulation, myofascial release, and therapeutic exercises rendered from 10/7/02 through 10/21/02 were found to be medically necessary.

The electrical stimulation, myofascial release, and therapeutic exercises rendered from 10/22/02 through 11/1/02 were not found to be medically necessary.

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 31, 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 respondent failed to submit copies of EOBs, therefore the charges not containing EOBs will be reviewed according to the Medical Fee Guideline.

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

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MAR$ | Reference | Rationale |
|---|---|---|---|---|---|---|---|
| 10/2/02<br>10/3/02 | 97110<br>97110 | $105.00<br>$70.00 | $0.00<br>$0.00 | C<br>C | $105.00<br>$70.00 | MFG, Medicine Ground Rule (I)(A)(9)(b), (I)(A)(10)(a) & (I)(A)(11)(a) | Review of the position statement submitted by Mega Rehab, dated 11/13/03 partially states; "…Mega Rehab is not contracted through any workers' compensation commission providers…" The |
| | 97250 | $43.00 | $0.00 | C | $43.00 | MFG, Medicine Ground Rule (I)(A)(9)(c) & (I)(C)(3) | |

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| | 97014 | $15.00 | $0.00 | C | $15.00 | MFG, Medicine Ground Rule (I)(A)(9)(a)(ii), (I)(A)(10)(a) | requestor, is therefore, entitled to the MAR reimbursement. Reimbursement is recommended in the amount of $857.00. |
| 10/14/02 | 97113 | $240.00 | $0.00 | C | $208.00 | MFG, Medicine Ground Rule (I)(A)(9)(b), (I)(A)(10)(a) | |
| 10/16/02 | 97113 | $240.00 | $0.00 | C | $208.00 | | |
| 10/18/02 | 97113 | $240.00 | $0.00 | C | $208.00 | | |
| 10/21/02 | 97110 | $105.00 | $0.00 | No EOB | $105.00 | MFG, Medicine Ground Rule (I)(A)(9)(b), (I)(A)(10)(a) & (I)(A)(11)(a)<br><br>CPT code descriptor<br><br>Section 413.016 | 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 need of exclusive 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.<br><br>The MRD declines to order payment because the daily notes did not indicate whether the doctor was conducting |

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| | | | | | | | exclusive one-to-one sessions with the claimant. The notes did not indicate the need for exclusive one-on-one supervision and there was no statement of the claimant's medical condition or symptoms that would warrant one-on-one supervision for an entire session or over an entire course of treatment Reimbursement is not recommended. |
| 10/21/02 | 99213 | $60.00 | $0.00 | No EOB | $48.00 | MFG, Evaluation/ Management Ground Rule (VI)(B) | Review of the office note dated 10/21/02 supports delivery of service. Reimbursement is recommended in the amount of $48.00. |
| TOTAL | | $1,118.00 | $0.00 | | $1,010.00 | | The requestor is entitled to reimbursement in the amount of $905.00. |

**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 10/2/02 through 10/21/02 in this dispute.

This Order is hereby issued this 13th day of February 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

October 20, 2003

**NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-03-3252-01**

___ 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 physician 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. This physician is board certified in physical medicine and rehabilitation. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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 ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 48 year-old female who sustained a work related injury on ___. The patient reported that while at work she sustained an injury to her neck, upper back and bilateral shoulders when she attempted to lift and pull covers of a king size bed. The patient underwent a left shoulder arthroscopy and is presently diagnosed with bilateral upper trapezius myofascitis. Postoperatively the patient was treated with physical therapy. The patient reported that during the postoperative physical therapy she sustained a re-injury to the right shoulder. The patient transferred her care to another facility where physical therapy consisting of electrical stimulation, myofascial releases and therapeutic procedures was restarted.

Requested Services

Electrical stimulation, myofascial release and therapeutic procedure from 10/7/02 through 11/1/02.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a patient with bilateral shoulder pain who status post left shoulder surgery. The ___ physician reviewer also noted that the patient re-injured her right shoulder during physical therapy and started physical therapy at a different facility. The ___ physician reviewer indicated that from 10/7/02 through 10/21/02 the patient showed good improvement in the right shoulder demonstrated by increased range of motion and was within normal limits by 10/21/02. However,

the ___ physician reviewer explained that the patient continued to complain of pain in her left shoulder with a decline of range of motion. The ___ physician reviewer noted that the patient showed improvement with right shoulder motor strength to within normal limits by 10/21/02 but had continued decreased strength in her left shoulder. The ___ physician reviewer explained that the patient responded well to treatment from 10/7/02 through 10/21/02 in the right shoulder. However, the ___ physician reviewer also explained that the range of motion in the left shoulder had declined and there was no real change in pain or motor strength during treatment from 10/7/02 through 10/21/02. The ___ physician reviewer further explained that the documentation provided did not demonstrated objective measurement in left shoulder range of motion/motor strength/pain as of 11/1/02. Therefore, the ___ physician consultant concluded that the electrical stimulation, myofascial release and therapeutic procedure from 10/7/02 through 10/21/02 were medically necessary to treat this patient's condition. However, the ___ physician consultant also concluded that the electrical stimulation, myofascial release and therapeutic procedure from 10/22/02 through 11/1/02 were not medically necessary to treat this patient's condition.

Sincerely,