MDR Tracking Number: M5-03-3264-01

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 08-13-03.

The IRO reviewed office visits, DME (neuromuscular stimulator), ROM, therapeutic procedures and activities that were denied based upon “U” and “V”

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for office visits, DME (neuromuscular stimulator), ROM, therapeutic procedures and activities from 03/25/03 through 06/13/03. Consequently, the requestor is not owed a refund of the paid IRO fee.

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.

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

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
04/08/03	97110	140.00	35.00	F	$105.00		*See rational below
TOTAL		140.00					The requestor is not entitled to reimbursement.

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 has reviewed the matters in light all of the Commission requirements for proper documentation. Documentation submitted to support the fee component in this dispute does not clearly delineate the severity of the injury requiring exclusive one –on- one treatment. On this basis the MRD declines to order payment.

This Decision is hereby issued this 6th day of January 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

October 17, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-3264-01

___ 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 was climbing up a ladder when he slipped and fell on his right elbow. The diagnoses for this patient included right elbow contusion, fractured distal radius and ulna on the right elbow and right elbow sprain/strain. X-Rays from 12/15/02 indicated accessory ossification at the level of lateral humeral condyle. An MRI from 3/26/03 showed abnormal moderate volume effusion descending into the joint capsule and possible inflammation or fracture was noted. The patient underwent surgery that consisted of an arthrotomy of the right lateral condyle with excision of small articular loose body and irrigation of the joint. Post surgically the patient has been treated with physical therapy and an elbow splint.

Requested Services
Office visits, DME (neuromuscular stimulator), ROM, therapeutic procedures and activities from 3/25/03 through 6/13/03.

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 injury to his right elbow on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included right elbow contusion, fractured distal radius and ulna on the right elbow and right elbow sprain/strain. The ___ physician reviewer further noted that the patient underwent surgery and was treated postoperatively with physical therapy and an elbow splint. The ___ chiropractor reviewer explained that the patient underwent an MRI on 3/26/03 that indicated possible inflammation or fracture of the right elbow was present. The ___ chiropractor reviewer also explained that the MRI findings were positive objective evidence that supports the need for active ongoing care. Therefore, the ___ chiropractor consultant concluded that the office visits, DME (neuromuscular stimulator), ROM, therapeutic procedures and activities from 3/25/03 through 6/13/03 were medically necessary to treat this patient's condition at this time.

Sincerely,