MDR Tracking Number: M5-03-3286-01

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 08-14-03.

The IRO reviewed initial visit and x-rays, thoracic lumbar, shoulder x-rays, office visits, therapeutic exercises, manual traction, myofasical release, joint mobilization, range of motion test, special reports, muscle testing, and upper MRI rendered from 04-11-03 through 05-21-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for thoracic lumbar, shoulder x-rays, office visits, therapeutic exercises, manual traction, myofasical release, joint mobilization, range of motion test, special reports, muscle testing, and upper MRI rendered after 04-25-03. On this basis, the total amount recommended for reimbursement ($2860.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for initial visit and x-rays, thoracic lumbar, shoulder x-rays, office visits, therapeutic exercises, manual traction, myofasical release, joint mobilization, range of motion test, special reports, muscle testing, and upper MRI rendered from 04-11-03 through 04-25-03. 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.

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 24, 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
05-13-03	97265	$43.00	0.00	No EOB	$43.00	MFG MGR (I)(C)(3)	Soap notes confirm delivery of service. Recommended reimbursement $43.00
	97250	$43.00	0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes confirm delivery of service. Recommended reimbursement $43.00
	97122	$35.00	0.00		$35.00	**MFG MGR (I)(A)(10)** (a)	Soap notes do not confirm delivery of service. Reimbursement is not recommended.
	97110 (4 units)	$140.00	0.00		$35.00 per unit	MFG MGR (I)(A)(9)(b)	See Rational below
	99213	$48.00	0.00		$48.00	MFG E/MGR (IV)(C)(2)	Soap notes confirm delivery of service. Recommended reimbursement $48.00
05-19-03	99213	$48.00	0.00		$48.00	MFG E/MGR (IV)(C)(2)	Soap notes confirm delivery of service. Recommended reimbursement $48.00
	97265	$43.00	0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes confirm delivery of service. Recommended reimbursement $43.00
	97250	$43.00	0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes confirm delivery of service. Recommended reimbursement $43.00
	97122	$35.00	0.00		$35.00	**MFG MGR (I)(A)(10)** (a)	Soap notes do not confirm delivery of service. Reimbursement is not recommended.
	97110 (4 units)	$140.00	0.00		$35.00 per unit	MFG MGR (I)(A)(9)(b)	See Rational below
	97750MT	$43.00	0.00		$43.00	MFG MGR (I)(E)(3)	Reports identifying the service provided, results and interpretation of the test were not submitted to support delivery of service. Reimbursement is not recommended.
TOTAL		$618.00					The requestor is entitled to reimbursement of **$225.00**

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 has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because) the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

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

Georgina Rodriguez
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 Decision is applicable for dates of service 04-11-03 through 04-25-03, 05-13-13-03 and 05-19-03 in this dispute.

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

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

February 20, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Corrected Disputed Services & Rationale

Re: MDR #: M5-03-3286-01
IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Brief Clinical History:
This claimant injured his right shoulder, abdominal area and back at work on ___. He describes his pain as constant aching with occasional episodes of muscle spasms.

Disputed Services:
Initial visit and x-rays on 04/11/03, thoracic, lumbar, and shoulder x-rays, and office visits (99213 and 99203), therapeutic exercises (97110), manual traction (97122), myofascial release (97250), joint mobilization (97265), range of motion test (95851), unlisted therapeutic procedure (97139), special report (99080-73), muscle testing (99750-MT), and upper MRI, from 04/17/03 through 05/21/03.

Decision:
The reviewer partially agrees with the determination of the insurance carrier. The services from 04/11/03 through 04/25/03 were medically necessary. The services rendered after 04/25/03 were not medically necessary.

Rationale:
The rationale for my decision comes from the *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* published in 1993. These are the most current such guidelines available. Also, the 1990 *Rand Consensus Panel* unanimously agreed to a definition of adequate therapeutic trial for spinal manipulation and/or passive modalities with related conditions. They recommended a trial of two weeks each utilizing passive modality procedures before considering treatment or care to have failed. Without evidence of progressive improvement over this time frame, spinal manipulation and passive procedures are no longer indicated.

The initial visit and x-rays provided information necessary to the treatment of the patient. During the patient's initial two-week therapeutic trial, consisting of therapeutic exercise, therapeutic procedures, manual procedures including myofascial release, joint mobilization, and manual traction, no changes were noted by any of the attending doctors in this case, with the exception of about a 10% improvement in the pain with the inguinal hernia noted by the patient toward the end of his second week of care. This fact is incidental in this case, as the treatment being rendered did not address the hernia. Such being the case, care should have been discontinued at the end of two weeks and the patient referred to another doctor for treatment of his injuries. After two weeks of care with no improvement, no further treatment of this nature can be justified by the currently available literature.

Additional Comments: With the injuries such as the patient received, I am recommending a full two-week trial, even though the patient was being seen on a daily basis during those two weeks. The nature of the injuries justifies a full two-week trial period.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,