MDR Tracking Number: M5-03-3332-01

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 08-20-03.

The IRO reviewed special reports, electrical stimulation, therapeutic procedures, range of motion tests, joint mobilization, myofasical release, paraffin bath, and muscle testing rendered from 01-03-03 through 06-04-03 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 special reports, electrical stimulation, therapeutic procedures, range of motion tests, joint mobilization, myofasical release, paraffin bath, and muscle testing from 03-04-03 through 06-04-03. 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 special medical reports from 01-03-03 and 02-17-03. 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 11-17-03, 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
10-21-02	99213-MP	$51.00	0.00	No EOB	$48.00	MFG, MGR (I)(B)(1)(b)	Soap notes support delivery of service. Recommended Reimbursement $48.00
11-04-02	99213-MP	$51.00	0.00		$48.00	MFG, MGR (I)(B)(1)(b)	Soap notes confirm delivery of service. Recommended Reimbursement $48.00
	L3800	$49.00	0.00		$39.00	MFG DME	Soap notes confirm delivery of service. Recommended Reimbursement $39.00
11-25-02	99213-MP	$51.00	0.00		$48.00	MFG, MGR (I)(B)(1)(b)	Soap notes confirm delivery of service. Recommended Reimbursement $48.00

12-05-02	99080-73	$15.00	0.00	No EOB	$48.00	Rule 129.5	Relevant information was not submitted to confirm delivery of service. Reimbursement is not recommended
12-17-02	99213-MP	$51.00	0.00		$48.00	MFG, MGR (I)(B)(1)(b)	Relevant information was not submitted for date of service to confirm delivery of service. Reimbursement is not recommended
03-31-03	97110 (2 units)	$74.00	0.00		$35.00 per unit	MFG, MGR (I)(A)(9)(b)	See Rationale below
04-17-03	97018	$16.00	0.00		$16.00	MFG MGR (I)(A)(9)(a)(iii)	Soap notes confirm delivery of service. Recommended Reimbursement $16.00
	97110	$111.00	0.00		$35.00 per unit	MFG, MGR (I)(A)(9)(b)	See Rationale Below
	97250	$46.00	0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes confirm delivery of service. Recommended Reimbursement $43.00
	97265	$46.00	0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes confirm delivery of service. Recommended Reimbursement $43.00
	99213	$51.00	0.00		$48.00	MFG, E & M GR(IV)(C)(2)	Soap notes confirm delivery of service. Recommended Reimbursement $48.00
06-10-03	97018	$16.00	0.00	No EOB	$16.00	MFG MGR (I)(A)(9)(a)(iii)	Soap notes confirm delivery of service. Recommended Reimbursement $16.00
	97110	$74.00	0.00		$35.00 per unit	MFG, MGR (I)(A)(9)(b)	See Rationale below
	97250	$46.00	0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes confirm delivery of service. Recommended Reimbursement $43.00
	97265	$46.00	0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes confirm delivery of service. Recommended Reimbursement $43.00
	99213	$51.00	0.00		$48.00	MFG, E & M GR(IV)(C)(2)	Soap notes confirm delivery of service. Recommended Reimbursement $48.00
06-12-03	97750-FC (4 hours)	$420.00	0.00		$100.00 per hour	MFG MGR (I)(E)(2)(a)	Report submitted confirms delivery of service. Recommended Reimbursement $400.00
06-13-03	99455-RP	$53.00	0.00		$50.00	MFG E/M GR (XXII)(D)(2)	Soap notes support review of report by treat doctor and therefore Recommended Reimbursement $50.00
TOTAL		$1108.00					The requestor is entitled to reimbursement of **$**933.00

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.

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 10-21-02 through 06-13-03 in this dispute.

This Decision is hereby issued this 4th day of May 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Amended Letter
Note: Decision

November 13, 2003

MDR Tracking #: M5-03-3332-01
IRO Certificate #: IRO 4326

The ___ 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 ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ 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 care. ___ 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 ___ 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 sustained an injury on ___ when his left hand was crushed between a metal wall and a metal pipe. He eventually underwent a left radical synovectomy and left De Quervain's release on 03/04/03.

Requested Service(s)
Medical reports, electrical stimulation therapy, therapeutic procedure, range of motion tests, joint mobilization, myofascial release, paraffin bath, and muscle testing from 01/03/03 through 06/04/03

Decision
It is determined that the medical reports, electrical stimulation therapy, therapeutic procedure, range of motion tests, joint mobilization, myofascial release, paraffin bath, and muscle testing from 01/03/03 through 03/04/03 were medically necessary to treat this patient's condition. However, the medical reports, electrical stimulation therapy, therapeutic procedure, range of motion tests, joint mobilization, myofascial release, paraffin bath, and muscle testing from 03/04/03 through 06/04/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision
The therapeutics and testing were not appropriate from 01/03/03 through 03/04/03, given the need for invasive applications. The therapeutics and testing from 03/04/03 through 06/13/03 were medically indicated as this was in the postoperative phase and rehabilitation was indicated.

Invasive surgical applications that included a left radical synovectomy of the volar flexor tendons and a left De Quervain's release were performed on 03/04/03. A clear need for post-surgical rehabilitation applications is evident. Maximum medical improvement (MMI) and an impairment rating of 6% were assigned on 05/19/03. Given the delays of appropriate care and necessary surgical interventions, the patient's course of post operative therapeutics was prolonged to some degree. Therefore, it is determined that the medical reports, electrical stimulation therapy, therapeutic procedure, range of motion tests, joint mobilization, myofascial release, paraffin bath, and muscle testing from 01/03/03 through 03/03/03 were medically necessary.

However, the medical reports, electrical stimulation therapy, therapeutic procedure, range of motion tests, joint mobilization, myofascial release, paraffin bath, and muscle testing from 03/04/03 through 06/04/03 were not medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- *Clinical practice guidelines for chronic, non-malignant pain syndrome patients II: An evidence-based approach.* J Back Musculoskeletal Rehabil 1999 Jan 1;13;47-58.

- Roberts-Yates C. *The concerns and issues of injured workers in relation to claims/injury management and rehabilitation: the need for new operational frameworks.* Disabil Rehabil. 2003 Aug 19; 25(16): 898-907.

Sincerely,