MDR Tracking Number: M5-03-3389-01

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, 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 08-27-03.

The IRO reviewed motor and sensory nerve conduction studies, cervical traction unit (DME), therapeutic exercises, unusual travel, group therapeutic procedures, office visits, office visits with manipulation, myofascial release, ultrasound therapy, electric muscle stimulation and hot/cold pack therapy rendered from 09-10-02 through 01-31-03 was denied based upon “U”.

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.

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 12-02-03, 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$**	**Reference**	**Rationale**
8-28-02 to 1-6-03 (3 DOS)	99080-73	$20.00 (1 unit)	$0.00	F	DOP	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to meet DOP criteria for dates of service 8-28-02 and 1-6-03. Requestor did not submit relevant information to meet DOP criteria for date of service 9-27-02. Reimbursement is recommended in amount of $20.00 X 2 DOS = $40.00
8-30-02	99213	$60.00 (1 unit)	$0.00	N	$48.00	96 MFG E/M GR (VI)(B)	Requestor submitted relevant information to meet documentation criteria. Reimbursement is therefore recommended in the amount of $48.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
9-18-02	A4556	$50.00 (1 unit)	$0.00	G	DOP	96 MFG DME GR IX (A)(C)	G – Not global. Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.
9-27-02	99214	$77.00 (1 unit)	$0.00	N	$71.00	96 MFG E/M GR (VI)(B)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in amount of $71.00
10-3-02	99215	$110.00 (1 unit)	$0.00	N	$103.00	96 MFG E/M GR (VI)(B)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in amount of $103.00
10-5-02	99243	$158.00 (1 unit)	$0.00	F	$116.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of $116.00
10-5-02	95861	$242.33 (1 unit)	$0.00	F	$200.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of $200.00
10-21-02	99204	$140.00 (1 unit)	$0.00	F	$106.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of $106.00
12-9-02 through 12-23-02 (5 DOS)	97010	$15.00 (1 unit X 5 DOS)	$55.00 ($11.00 paid on each DOS)	F	$11.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement has been made at MAR. No additional reimbursement is recommended.
12-23-02	97110	$160.00 (4 units)	$70.00	F,M	$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement is recommended.
TOTAL		$1132.33	$125.00		$839.00		The requestor is entitled to reimbursement in the amount of $684.00

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 theseindividual 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 12th day March 2004.

Debra L. Hewitt
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 08-28-02 through 01-31-03 in this dispute.

This Order is hereby issued this 12th day of March 2004.

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

NOTICE OF INDEPENDENT REVIEW DECISION - AMEND

Date: March 3,2004

RE: MDR Tracking #: M5-03-3389-01
IRO Certificate #: **5242**

___ 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 proposed 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 Chiropractic physician reviewer that has ADL certification. The Chiropractic physician reviewer 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

According to the supplied documentation, it appears that the claimant injured his head and cervical spine on ___when a roof hatch door closed prematurely on his head. The claimant was treated at the emergency room and released. On 08/14/2002, the claimant was evaluated by ___ Passive chiropractic therapy began. Plain film x-rays were performed on 08/15/2003, which revealed degeneration at C5-6 and C6-7 with limited flexion and extension. A MRI was performed on 08/19/2002, which revealed disc degeneration at C6-7 and an anterior bulge of the disc at C5-6. More plain film x-rays were taken on 08/21/2002 of the claimant's bilateral AC joints with slight widening of the AC joint with weight applied. A MRI of the right shoulder was performed on 08/26/2003 and revealed degenerative changes of the AC joint and tendinitis of the supraspinatus tendon. On 10/01/2003, the claimant was seen by ___ who felt surgical intervention was needed on the claimant's right shoulder. On 10/05/2003, a nerve conduction velocity/electromyogram revealed C5-6 radiculopathy associated with the MRI findings. ___ performed surgery on the claimant's right shoulder on 10/09/2003. On 11/01/2002 and on 01/10/2003, the claimant had a epidural steroid injection at C5-6 performed by ___ Active and passive therapy followed both injections.

Requested Service(s)

Please review and address the medical necessity of the outpatient services including motor and sensory nerve conduction studies, a cervical traction unit (DME), therapeutic exercises, unusual travel, group therapeutic procedures, office visits, office visits with manipulations, myofascial release, ultrasound therapy, electric muscle stimulation and hot/cold packs rendered between 09/10/2002 – 01/31/2003.

Decision

I agree with the insurance company that the office visits dated 09/18/2002, 09/20/2002, 09/23/2002, 09/25/2002, 09/27/2002, 09/30/2002, 10/02/2002, and on 10/04/2002 were not medically necessary. I agree that the unusual travel and DME were not necessary. I also agree that the therapy sessionsin their entirety rendered on 12/23/2003, 01/06/2003, 01/08/2003, and 01/31/2003 were not necessary. I disagree with the insurance company and agree with the treating doctor that the remainder of services rendered between 09/10/2002 – 01/31/2003 including NCV studies, therapeutic procedures, group therapeutic activities, myofascial release, ultrasound therapy, electric muscle stimulation, and hot/cold packs were medically necessary.

Rationale/Basis for Decision

The claimant sustained an injury to his cervical spine and shoulder on ___. Current medical protocols validate passive and active modalities during the first 8-12 weeks post injury. The claimant had surgery on his right shoulder on 10/09/2002 and after the surgeon released him, he would also need to undergo rehabilitation for his shoulder. After a MRI revealed a disc bulge at C5-6, an EMG/NCV test would be necessary to evaluate possible nerve root involvement. The claimant underwent 2 epidural steroid injections during the disputed period. After an ESI, 2 weeks of therapy is warranted for relief of symptoms. Continued therapy beyond the 2-week period is not considered reasonable or medically necessary. The referrals to other physicians and their evaluation visits are considered reasonable in the management of the claimant's case. Office visits billed on every treatment is not considered reasonable or necessary for proper management in the claimant's case. Monthly visits would be sufficient enough to make proper referrals and needed recommendations. There was not sufficient objective documentation to warrant a cervical traction unit that would benefit the claimant compensable injuries. There was no objective documentation supplied to support any rationale for the unusual travel expenses.