MDR Tracking Number: M5-03-0040-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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.

The IRO reviewed chiropractic treatment and diagnostic studies rendered from 09-10-01 to 4-29-02 that were denied based upon "U" or "T".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO determined that treatment up to 9-30-01 was medically necessary. Services from 10-1-01 through 4-29-02 were not medically necessary. The following table identifies the services rendered that were found medically necessary.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
9-10-01 9-13-01 9-19-01 9-20-01 9-21-01 9-25-01 9-26-01 9-28-01	97110	$140.00	$35.00 $35.00 $35.00 $35.00 $35.00 $105.00 $105.00 $105.00	T	$35.00/15 min	Medicine GR (I)(A)(9)(b) and (I)(C)9)	IRO concluded these services were medically necessary; therefore reimbursement of 8 X $140.00 = $1120.00 minus amount paid of $490.00 = $630.00 is recommended.
9-14-01	97110	$210.00	$35.00	T	$35.00/15 min	Medicine GR (I)(A)(9)(b) and (I)(C)9)	IRO concluded these services were medically necessary; therefore reimbursement of $210.00 minus $35.00 = $175.00 is recommended.
TOTAL		$4452.00					The requestor is entitled to reimbursement of **$805.00.**

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Consequently, the commission has determined that **the requestor did not prevail** on the majority of the medical fees ($805.00). Consequently, the requestor is not owed a refund of the paid IRO fee.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On April 17, 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
10-16-01 4-18-02	99080-73	$15.00	$0.00	F	$15.00	Rule 129.5(d) Rule 133.106	Claimant's work status did not change; therefore, the filling of report was not in compliance with statute. No reimbursement is recommended.
10-16-01 4-18-02	95851 97750MT	$40.00 $172.00	$0.00	G	$36.00 each $43.00 /body area	CPT code Description Medicine GR (I)(E)(2) (a) and (b)(i)(ii)(iii) Medicine GR (I)(E)(3) TWCC and the Importance of Proper Coding	The requestor billed for a comprehensive office visit, range of motion testing and muscle testing on these dates. On 10-16-01 the requestor billed $352.00 for the services. On 4-18-02 the requestor billed $452.00 for the services. The carrier reimbursed the provider $103.00 for the comprehensive office visit on 10-16-01. Range of Motion testing and Muscle testing are not global to

4-18-02	99215	$125.00	$0.00	N	$103.00		the office visit. Medical records indicate that the initial physical capacity test was performed on 6-26-01. The requestor noted that on these dates physical capacity testing was done. Per Medicine GR (I)(E)(2)(b)(ii), physical capacity evaluations are a component of a FCE. The MFG states that physical evaluations, range of motion and muscle testing are global to a Functional Capacity Evaluation. Per Medicine GR (I)(E)(3), "muscle testing may replace six components of the functional abilities test and shall be reimbursed (by time required) as a component of the FCE, not exceeding the MAR for an FCE." Therefore, the requestor is entitled to reimbursement of the MAR for 2nd and Final FCE of $200.00. On 10-16-01, the requestor was paid $103.00. The requestor is entitled to the difference between $200.00 and amount paid of $103.00 = $97.00 for 10-16-01. The requestor is entitled to reimbursement of $200.00 for 4-18-02.
TOTAL							The requestor is entitled to reimbursement of **$ 297.00.**

This Decision is hereby issued this 12th day of August 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

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 9-10-01 through 4-29-02 in this dispute.

This Order is hereby issued this 12th day of August 2003.

Roy Lewis
Medical Dispute Resolution Supervisor
Medical Review Division

December 9, 2002

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0040-01

___ 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 ___ external review panel. ___ 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, ___ chiropractor 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 man who sustained a work related injury to his lower back on ___. The patient is a truck driver and his duties include hauling sand and waste products. He stated that he needs to repeatedly use his left leg on the clutch of his truck. He also stated that on ___, he had to clean out the back of his truck of with a shovel and that this caused discomfort in his lower back but that he continued working through his pain. The patient has had an MRI. The

diagnoses for this patient were Displacement of Lumbar Intervertebral Disc without Myelopathy, Lumbar Facet Syndrome, and Myofascial Pain Syndrome. Treatmetnt has included heat, home exercises, chiropractic management and physical medicine treatments including passive and active therapy.

Requested Services

Physical Therapy and office visits rendered from 9/10/01 through 4/29/02.

Decision

The Carrier's denial of coverage for these services is partially overturned.

Rationale/Basis for Decision

___ chiropractor reviewer noted that the patient sustained a work related injury to his back on ___. ___ chiropractor reviewer also noted that the patient was treated with heat, home exercises, chiropractic management and physical medicine treatments including passive and active therapy. ___ chiropractor reviewer further noted that the patient reported no improvement with treatments rendered except with the Epidural Steroid Injections and surgery itself. ___ chiropractor consultant explains that the services rendered up to 9/30/01 are medically necessary. ___ chiropractor consultant also explained the care given from 10/1/01 to 4/29/02 showed no significant or lasting improvement in the patient's condition or pain level. Therefore, ___ chiropractor consultant concluded that care given up to 9/30/01 was medically necessary. ___ chiropractor consultant further concluded services from 10/1/01 through 4/29/02 were not medically necessary for the treatment of the patient's condition.

Sincerely,

___