MDR Tracking Number: M5-03-0240-01

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 Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 March 14 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
9-13-01 9-17-01 9-19-01 9-21-01	97265 97250 97530 97112	$45.00 $45.00 $216.00 $40.00	$0.00	V	$43.00 $43.00 $35.00/15 min $35.00/15 min	Rule 134.600 Rule 133.301(a)	The insurance carrier gave preauthorization approval on 8-31-01 for physical therapy services three times a week for three weeks. These services will be reviewed per *Medical Fee Guideline.* The requestor

							did not submit reports to support physical therapy services rendered on 9-13-01, 9-17-01 and 9-19-01; therefore, reimbursement for the physical therapy treatment is not recommended for these dates. The requestor submitted a report for 9-21-01 supporting physical therapy services rendered; therefore, $346.00 reimbursement is recommended.
10-17-01 10-18-01 10-22-01 10-23-01 10-24-01	97546 (x4)	$256.00	$0.00	No EOB	$51.20/hr for Non CARF accredited program X 4 = $204.80		The requestor submitted work hardening reports to support billed service; therefore, reimbursement per *Medical Fee Guideline* of 5 X $204.80 = $1024.00 is recommended.
10-25-01 10-16-01 10-29-01	97545	$128.00	$0.00	No EOB	$51.20/hr for Non CARF accredited program X 2 = $102.40	Medicine GR (II)(C) and (E)	The requestor submitted work hardening reports to support billed service; therefore, reimbursement per *Medical Fee Guideline* of 3 X

							$102.40 = $307.20 is recommended.
10-25-01 10-26-01 10-29-01	97546	$256.00	$0.00	No EOB	$51.20/hr for Non CARF accredited program X 4 = $204.80	Medicine GR (II)(C) and (E)	The requestor submitted work hardening reports to support billed service; therefore, reimbursement per *Medical Fee Guideline* of 3 X $204.80 = $614.40 is recommended.
10-18-01	97545	$128.00	$102.40	F	$51.20/hr for Non CARF accredited program	Medicine GR (II)(C) and (E)	The HCFA-1500s do not indicate that the work hardening program was a CARF accredited program. Therefore, the insurance carrier correctly reduced reimbursement per *Medical Fee Guideline.*
10-18-01 10-25-01 11-1-01	99070	$15.00	$12.75	M	DOP	Section 413.011(b)	The requestor failed to submit documentation to support amount billed complied with Section 413.011(b); therefore, additional reimbursement is not recommended.
10-17-01 10-22-01	99070	$15.00	$0.00	No EOB	DOP	General Instructions GR	The requestor submitted

10-23-01 10-24-01 10-26-01 10-29-01						(IV)	reports that indicate arctic ice was provided to claimant. Therefore, reimbursement per *Medical Fee Guideline* 6 X $15.00 = $90.00 is recommended
TOTAL		$4079.00					The requestor is entitled to reimbursement of **$2381.60.**

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 $2381.60 plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is hereby issued this 2nd day of July 2003.

Roy Lewis
Medical Dispute Resolution Supervisor
Medical Review Division

January 7, 2003

Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: Medical Dispute Resolution
MDR# : M5-03-0240-01
IRO Certificate No.: IRO 5055

Dear:

___ 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 Board Certified in Chiropractic medicine.

Clinical History:
This male claimant suffered injury to right and left knees, as well as incurring some neck and shoulder pain from an accident on ___.

Disputed Services:
Office visits, physical therapy, durable medical equipment, supplies and work hardening program from 09/13/01 through 11/01/01.

Decision:
The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the treatments and services in question were not medically necessary in this case.

Rationale for Decision:
Twelve weeks of rehabilitation is more than sufficient for the patient to reach maximum benefits from the treatment provided. Guidelines and Practices for Chiropractic Care state that surgical referral should be considered in cases of patients with severe, unrelenting pain, after three months of conservative treatment without improvement, or in cases involving loss of shoulder function.

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 who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,