

MDR Tracking Number: M5-03-0602-01

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 rendered from 5-8-02 to 5-15-02 that was denied based upon "U".

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.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
5-8-02	97110 (2 units)	\$70.00	\$0.00	U	\$35.00/ 15 min	Section 408.021(a)	IRO concluded these services were medically necessary; therefore reimbursement of \$70.00 is recommended.
5-9-02 5-13-02 5-15-02	97110 (3 units)	\$105.00	\$0.00	U	\$35.00/ 15 min	Section 408.021(a)	IRO concluded these services were medically necessary; therefore reimbursement of 3 dates \$105.00 = \$315.00 is recommended.
5-8-02 5-9-02 5-13-02	99212	\$32.00	\$0.00	U	\$32.00	Section 408.021(a)	IRO concluded these services were medically necessary; therefore reimbursement of 3 dates X \$32.00 = \$96.00 is recommended.
5-8-02 5-9-02 5-13-02 5-15-02	97139PH	\$35.00	\$0.00	U	DOP	Medicine GR (l)(C)(1)(r)	IRO concluded these services were medically necessary; therefore reimbursement of 4 dates X \$35.00 = \$140.00 is recommended.
5-8-02 5-9-02 5-13-02 5-15-02	99070PH	\$7.00	\$0.00	U	DOP	General Instructions GR (IV)	IRO concluded these services were medically necessary; therefore reimbursement of 4 dates X \$7.00 = \$28.00 is recommended.
5-15-02	99213	\$48.00	\$0.00	U	\$48.00	Section 408.021(a)	IRO concluded these services were medically necessary; therefore reimbursement of \$48.00 is recommended.
TOTAL		\$697.00					The requestor is entitled to reimbursement of \$697.00 .

The IRO concluded that only one form of therapy was necessary. The consultant concluded that the Phonophoresis and Phonophoresis supplies, office visits, and therapeutic procedures from 5-8-02 through 5-15-02 were medically necessary; however, the aquatic therapy from 5-8-02 through 5-15-02 were not medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees (\$697.00). Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for 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.

On April 25, 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:

Services that were denied with EOB denial code "D" will be reviewed in accordance with *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
5-7-02	99214	\$71.00	\$0.00	D	\$71.00	Evaluation & Management GR (IV) and (VI)	Interim report supports billed service, reimbursement of \$71.00 is recommended.
5-16-02 5-20-02 5-22-02 5-27-02 5-29-02 5-30-02	97139PH	\$35.00	\$0.00	D	DOP	Medicine GR (I)(C)(1)(r)	SOAP note supports billed service, reimbursement of 6 dates X \$35.00 = \$210.00 is recommended.
5-27-02 5-30-02	97265	\$43.00	\$0.00	D	DOP	Medicine GR (I)(C)(1)(m)	SOAP note supports billed service, reimbursement of 2 dates X \$43.00 = \$86.00 is recommended.
5-30-02	97110 (4 units)	\$140.00	\$0.00	D	\$35.00/ 15 min	Medicine GR (I)(A)(9)(b)	SOAP note supports billed service, reimbursement of \$140.00 is recommended.
5-16-02 5-20-02 5-22-02 5-27-02 5-29-02	97110 (3 units)	\$105.00	\$0.00	D	\$35.00/ 15 min	Medicine GR (I)(A)(9)(b)	SOAP note supports billed service, reimbursement of 5 dates X \$105.00 = \$525.00 is recommended.
5-16-02	99212	\$32.00	\$0.00	D	\$32.00	Evaluation &	SOAP notes support billed

5-20-02 5-22-02 5-27-02 5-29-02 5-30-02						Management GR (IV) and (VI)	service, reimbursement of 6 dates X \$32.00 = \$192.00.	
5-16-02 5-20-02 5-22-02 5-27-02 5-29-02 5-30-02	99070PH	\$7.00	\$0.00	D	DOP	General Instructions GR (IV)	SOAP note supports billed service, reimbursement of 6 dates X \$7.00 = \$42.00 is recommended.	
5-16-02 5-27-02 5-29-02 5-30-02	97124 (2 units)	\$56.00	\$0.00	D	\$28.00 / 15 min	CPT code description	SOAP note supports billed service, reimbursement of 4 dates X \$56.00 = \$224.00 is recommended.	
TOTAL							The requestor is entitled to reimbursement of \$965.00.	U

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 5-7-02 through 5-30-02 in this dispute.

This Decision and Order is hereby issued this 22nd day of August 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

March 21, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0602-01

___ 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 the ___ external review panel. The ___ 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, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 49 year-old female who sustained a work related injury to her back on ___. The patient reported that while at work as a custodian she was moving some cabinets. She tried to pick up a cabinet and set it on a dolly. The patient reported that while attempting to lift the cabinet, she twisted to her right side to set the cabinet on a dolly. During this motion the patient reported that she felt pain in her low back and right foot. The diagnoses for this patient included lumbar sprain, possible displacement of lumbar intervertebral disc, thoracic or lumbosacral neuritis or radiculitis, myalgia and myositis. The patient has undergone MRI on 8/12/99 and 6/12/00, and also an electro-diagnostic test on 8/18/99. The patient was found to have a re-exacerbation on exam 5/7/02 and was treated with aquatic therapy, massage therapy, therapeutic exercises and phonophoresis.

Requested Services

Phonophoresis and phonophoresis supplies, office visits, therapeutic procedure, and aquatic therapy from 5/8/02 through 5/15/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that the patient sustained a work related injury to her back on ___. The ___ physician reviewer also noted that the patient sustained a re-exacerbation on 5/7/02. The ___ chiropractor reviewer further noted that the patient was treated with phonophoresis, therapeutic procedures, aquatic therapy, and massage therapy. The ___ physician reviewer explained that only aquatic therapy or exercise therapy were medically necessary to treat this patient's condition per visit. The ___ chiropractor reviewer indicated that only one form of therapy was necessary to treat this patient's condition per visit. The ___ chiropractor reviewer also explained that all other procedures performed on each visit were medically necessary. Therefore, the ___ chiropractor consultant concluded that the phonophoresis and phonophoresis supplies, office visits, and therapeutic procedures from 5/8/02 through 5/15/02 were medically necessary. However, the ___ chiropractor consultant concluded that the aquatic therapy from 5/8/02 through 5/15/02 were not medically necessary to treat this patient's condition.

Sincerely,

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