MDR Tracking Number: M5-03-0802-01

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 work conditioning and work hardening program and FCE rendered from 4-9-02 to 10-30-02 that were 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(q)(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.

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

On February 24, 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 without an EOB will be reviewed in accordance with *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
9-20-02 9-25-02 10-9-02 10-14-02 10-15-02 10-18-02 10-24-02	97110	$140.00	$0.00	No EOB	$35.00 / 15 min	CPT Code description TWCC and the Importance of Proper Coding Medicine GR (I)(A)(9)(b)	Documentation does not support 1 to 1 supervision No reimbursement is recommended.
9-25-02	99213	$48.00	$0.00	No	$48.00	CPT Code	Progress notes supports billed

10-9-02 10-14-02 10-15-02 10-18-02 10-24-02				EOB		description	service. Reimbursement is recommended of 6 X $48.00 = $288.00.
10-15-02	97122	$70.00	$0.00	No EOB	$35.00 /15 min	CPT Code description	Progress notes supports billed service. Reimbursement is recommended of $70.00.
10-15-02	97014	$15.00	$0.00	No EOB	$15.00	CPT Code description	Progress notes supports billed service. Reimbursement is recommended of $15.00.
10-15-02	97250	$43.00	$0.00	No EOB	$43.00	CPT Code description	Progress notes supports billed service. Reimbursement is recommended of $43.00.
10-28-02 10-30-02	99090	$108.00	$0.00	No EOB	$108.00	CPT Code description	Documentation does not support billed service. No reimbursement is recommended .
TOTAL							The requestor is entitled to reimbursement of **$416.00.**

This Decision is hereby issued this 6th day of August 2003.

Elizabeth Pickle
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 4-9-02 through 10-30-02 in this dispute.

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.

This Order is hereby issued this 6th day of August 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

February 18, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-03-0802-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ was working as a stand-up fork lift driver for ___ warehouse on ___ when, during the course of his work activity, a touch screen computer monitor (weighing approximately 90 lbs.) fell and struck him on the head and left arm. The force of the impact knocked him from the forklift in such a manner that he landed on his buttocks with his arms stretched backward to catch himself.

On February 11, 2002 he was seen at ___ on ___ in ___ by ___. Her initial examination of ___ revealed (1) cervical pain with accompanying +2 to +3 muscle spasm and 40% decreased ROM in all planes and (2) lumbar pain revealed +2 to +3 spasm and 40% decreased ROM. Associated straight leg raising was 80 degrees on the right. (3) The patient's left forearm and hand revealed tenderness, edema and a central abrasion. ROM was decreased in the fifth finger. ___ initial diagnosis was cervical strain, lumbar strain, closed head injury, posttraumatic cephalgia and left hand contusion.

DISPUTED SERVICES

Under dispute are therapeutic procedures, office visits with manipulations, physical medicine treatment, special reports, joint mobilization, data analysis, myofascial release, and PT unlisted modality.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer finds that the care in question prior to the left shoulder surgery on 7/1/02 was appropriate, as the doctors were initially trying to avoid surgery with injections, physical therapy, physical medicine and manipulations. Surgeries of the cervical spine and left wrist, contemplated in April 2002, were avoided. The lumbar complaints were reduced. The care given obviously helped the patient with relief of pain and in recovery, as reflected in greater range of motion and improved activities of daily living. The reviewer also finds the care rendered after the 7/1/02 surgery was appropriate under the guidelines for pain relief and rehabilitation of the patient's symptoms – most specifically, the left shoulder.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,