

MDR Tracking Number: M5-03-0803-01

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 4-15-02 to 7-19-02 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 May 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
4-24-02	97110	\$140.00	\$0.00	T	\$35.00 / 15 min	CPT Code description TWCC and the Importance of Proper Coding Medicine GR (I)(A)(9)(b) HB 2600	HB 2600 abolished treatment guideline, effective 1-1-02; therefore, the insurance carrier incorrectly denied reimbursement based upon "T". Documentation does not support billed service. No reimbursement is recommended.
4-24-02	99213	\$48.00	\$0.00	T	\$48.00	HB 2600	HB 2600 abolished treatment guideline, effective 1-1-02; therefore, the insurance carrier incorrectly denied

							reimbursement based upon "T". Documentation does not support billed service. No reimbursement is recommended.
4-15-02 4-17-02 4-22-02 4-29-02 5-1-02 5-2-02 5-8-02 5-10-02	99213	\$48.00	\$0.00	F	\$48.00	CPT Code description	Documentation does not support billed service. No reimbursement is recommended.
4-24-02	97014	\$15.00	\$0.00	T	\$15.00	HB 2600	HB 2600 abolished treatment guideline, effective 1-1-02; therefore, the insurance carrier incorrectly denied reimbursement based upon "T". Documentation does not support billed service. No reimbursement is recommended.
4-24-02	97265	\$43.00	\$0.00	T	\$43.00		
4-24-02	97035	\$22.00	\$0.00	T	\$22.00	CPT Code description	
TOTAL							The requestor is not entitled to reimbursement.

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 4-15-02 through 7-19-02 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

March 12, 2003

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

Re: Medical Dispute Resolution
MDR #: M5.03.0803-01
IRO Certificate No.: 5055

Dear Ms. Lopez:

___ 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 crushed the tip of his right middle finger on ___ while on his job. He underwent a punch graft from the wrist and repair of his right middle finger.

Following a thorough evaluation and FEC's, a treatment program was begun of passive modalities to assist in the patient's recovery. He progressed into an active rehabilitation program and was, eventually, allowed to return to work light-duty.

Disputed Services:

Office visits, joint mobilization, therapeutic procedures, application of modality, supplies, and FCE's from 04/15/02 through 07/19/02.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the procedures and treatments named above were medically necessary in this case.

Rationale for Decision:

The records indicate the patient continued to improve from his injury as a direct result of the treatment plan outlined and performed by his treating physician. On 07/10/02, the patient was placed at maximum medical improvement and was given a 5% impairment rating, which was directly related to his on-the-job injury.

All services and testing performed on this patient were usual, reasonable, customary and medically necessary for the patient to recover and progress to the point where he was able to return to work.

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 or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,