

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-0364.M5

MDR Tracking Number: M5-03-0846-01

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 work hardening program rendered from 4-19-02 to 7-26-02 that were denied based upon "U".

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 February 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	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
2-11-02 2-13-02 2-15-02 3-1-02 4-5-02	97250	\$43.00	\$0.00	N	\$43.00	CPT Code description	2-13-02,2-15-02, 4-5-02 SOAP note does not document myofascial release. A SOAP note for 3-1-02 was not submitted to support billed service. 2-11-02 SOAP note documents treatment per MFG; therefore, payment of \$43.00 is recommended.
2-11-02 2-13-02	97110 (4 units)	\$140.00	\$70.00	N	\$35.00 / 15 min	Medicine GR	Documentation indicates treatment was one to one, however, does not

2-15-02 2-25-02 2-27-02 3-1-02 4-5-02						(I)(A)(9)(b)	document the medical necessity of one to one treatment, or the type of exercise performed, claimant's response to treatment; therefore, additional reimbursement is not recommended.
3-1-02	99213	\$48.00	\$0.00	N	\$48.00	CPT Code description	A SOAP note for 3-1-02 was not submitted to support billed service. Therefore, reimbursement is not recommended.
3-1-02	97035	\$22.00	\$0.00	N	\$22.00	CPT Code description	A SOAP note for 3-1-02 was not submitted to support billed service.
4-5-02	97265	\$43.00	\$0.00	N	\$43.00	CPT Code description	4-5-02 SOAP note does not document joint mobilization.
TOTAL							The requestor is entitled to reimbursement of \$43.00

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 2-11-02 through 7-26-02 in this dispute.

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

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

January 27, 2003

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

MDR Tracking #: M5-03-0846-01
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

The documentation states that ___ is a 22-year-old male who was injured on ____. The patient was working for ___ as a truck driver. On 12/2/01, ___ was driving a bus when a car cut him off the road. Documentation states that he tried to avoid the car and hit a concrete barrier. ___ sustained injuries to the left side of his body, and the documentation also states that he was taken to ___ for the cut on his head that required stitches.

The patient sought care at ___ where he was given medications and physical therapy for his condition. He was diagnosed with a laceration to the head and sprain/strain injuries to the cervical spine and left shoulder. On 1/15/02, ___ was referred for an orthopedic evaluation by ___ who diagnosed a Grade II acromioclavicular separation in the left shoulder. The patient changed treating doctors to ___ and continued active and passive care for his condition. The patient was referred for an MRI of the cervical region on 10/31/02 that displayed no abnormalities. He was then referred for an MRI of the left shoulder on 2/18/02 that displayed subacromial joint effusion to mild to moderate hypertrophy changes of the AC joint. ___ was referred for an EMG on 3/13/02 that showed a mild C7 radiculopathy on the left and a left mild median nerve lesion. The patient underwent an FCE for work hardening on 4/18/02.

DISPUTED SERVICES

Under dispute is the medical necessity of work hardening, office visits, and physical therapy are medically necessary for ___ from 4/29/02 through 7/26/02.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer disagrees with the medical necessity of physical therapy, office visits and work hardening for this patient for the dates 4/29/02 through 7/26/02. The orthopedic records from ___ dated 1/15/02 show this patient to be improving and to have nearly full range of motion in his left shoulder. ___ also stated that an active conditioning protocol of two weeks for this patient would be appropriate from the 1/15/02 date. The FCE also displays that this patient could handle his job description as of 4/18/02, and therefore also displays how this type of care would not have been warranted in this patient's claim.

The FCE results as well as the records from the other providers assisting in this patient's care were taken into account. The recommendations fall well within the Mercy Fee Guidelines, TCA Guidelines, and well within the Spinal Treatment Guidelines.

___ 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,