MDR Tracking Number: M5-03-0877-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution – General 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. This dispute was received on 12-2-02.

Dates of service submitted prior to 12-2-01 were submitted untimely per Rule 133.307(d)(1); therefore, they will not be considered in this Findings and Decision.

The IRO reviewed physical therapy, supplies and durable medical equipment rendered from 12-2-01 to 2-22-02 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 28, 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:

The Treatment Guidelines were abolished per House Bill 2600 on 1-1-02; therefore, the insurance carrier was incorrect to deny reimbursement based upon "T".

Services that were denied without an EOB and "T" will be reviewed in accordance with *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
1-2-02	97110	$216.00	$0.00	No EOB	$35.00 / 15 min	CPT Code description Medicine GR (I)(A)(9)(b)	SOAP report supports billed service. Reimbursement is recommended of $216.00
1-15-02 1-28-02	97530	$210.00	$101.75	No EOB	$35.00	CPT Code description	SOAP report supports billed service. Reimbursement is

							recommended of 2 dates X $210.00 = $420.00.
1-28-02	99213	$50.00	$0.00	No EOB	$48.00	CPT Code description	SOAP report supports billed service. Reimbursement is recommended $48.00.
1-28-02	97265	$43.00	$0.00	No EOB	$43.00	CPT Code description	SOAP report supports billed service. Reimbursement is recommended $43.00.
1-28-02	97250	$43.00	$0.00	No EOB	$43.00	CPT Code description	SOAP report supports billed service. Reimbursement is recommended $43.00.
1-28-02	99070	$15.00	$0.00	No EOB	DOP	General Instructions GR (IV)	SOAP report supports analgesic cream. Reimbursement of $15.00 is recommended.
1-28-02	E0745	$165.00	$0.00	No EOB	DOP	General Instructions GR (III)	SOAP report supports EMS unit monthly use. Reimbursement of $165.00 is recommended.
1-30-02 2-4-02 2-11-02 2-15-02 2-18-02 2-22-02	97122	$35.00	$00.00	T	$35.00	CPT Code description	SOAP reports supports billed service on 1-30-02 and 2-4-02. Reimbursement is recommended of 2 dates X $35.00 = $70.00. The requestor did not support manual traction in SOAP notes for the remaining dates.
2-1-02 2-5-02 2-7-02 2-13-02 2-20-02	97116	$38.00	$00.00	T	$38.00	CPT Code description	SOAP reports supports billed service. Reimbursement is recommended of 5 dates X $38.00 = $190.00.
1-4-02 1-7-02 1-9-02	97122	$35.00	$35.00	F	$35.00	CPT Code description	Paid per EOB. No reimbursement is recommended.
1-7-02 1-9-02 1-18-02	99213	$50.00	$48.00	F	$48.00	CPT Code description	Paid per EOB. No reimbursement is recommended.
1-7-02 1-9-02	97250	$45.00	$0.00	F	$43.00	CPT Code description	Paid per EOB. No reimbursement is recommended.
1-18-02	97530	$210.00	$210.00	F	$35.00 / 15 min	CPT Code description	Paid per EOB. No reimbursement is recommended.
TOTAL							The requestor is entitled to reimbursement of **$1210.00.**

This Decision is hereby issued this 3rd day of September 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 12-2-01 through 2-22-02 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 3rd day of September 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

February 6, 2003

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

MDR Tracking #:	M5-03-0877-01
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 injured in a work-related accident on ___. On that date, the patient was loading furniture onto a truck that had a broken and uneven floor. As he stepped into the truck, he lost his footing on this uneven area, causing him to twist and sprain his right ankle. The initial treating doctor fitted him with an ankle brace and crutches with no other treatment rendered. ___ was unable to return to work, as no light duty was available. He eventually came under the care of ___ who treated him through to MMI and assignment of a 4% whole person impairment.

DISPUTED SERVICES

Under dispute is the medical necessity of physical therapy, supplies and durable medical equipment rendered from 11/29/01 through 2/22/02.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

Upon review of the records submitted, the reviewer finds that physical therapy and therapeutic exercises were performed in an aggressive manner to quickly bring resolution to his case. All services and activities are properly documented and include the amount of time taken to perform them. There are subjective as well as objective improvements noted in the response to the treatment. This treatment appears to be reasonable and necessary , as it was instrumental in increasing function and controlling symptomatology so that the patient could return to gainful employment. The same successful result would not have come about utilizing an unsupervised exercise program at home. ___ treatments were intended to "cure or relieve" the symptoms resulting from the injury, as outlined in the Texas Worker's Act, section 401.001 (31).

With regards to the durable medical equipment and supplies, it appears the patient was prescribed an electric muscle stimulation machine to be used during home care to control pain and reduce spasm. This CPT code is E0745 and the disposable electrodes for the machine have been billed under code E1399. The other CPT code in question, 9970, is for a topical analgesic the doctor used to minimize pain during the performance of kinetic exercises. The TWCC Medicine Ground Rules state on page 31, 1(A)2 that the treatment in question should be "specific to the injury and provide potential improvement of ht patient's condition." As the utilization of the durable medical equipment and supplies was intended to relieve symptoms naturally occurring from the injury, they are considered medically necessary in this case.

___ 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,