MDR Tracking Number: M5-03-0979-01

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 12-16-02.

The IRO reviewed chiropractic treatment rendered from 12-13-01 to 10-16-02 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 April 22, 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 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
1-11-02 2-21-02 9-5-02	99213MP	$48.00	$0.00	No EOB	$48.00	Evaluation & Management GR (IV)	SOAP note supports service 1-11-02, support reimbursement of $48.00 is recommended. SOAP notes for remaining dates of service were not submitted, no reimbursement

							is recommended.
1-28-02 4-16-02	99090	$108.00	$0.00	F	$108.00	CPT Code Description	SOAP note for 1-28-02 did not support service. A report for 4-16-02 was not submitted to support service per MFG.
2-21-02	97250	$43.00	$0.00	F	$43.00	CPT Code Description	SOAP note for 2-21-02 was not submitted to support service per MFG.
2-21-02	97122 (2 units)	$70.00	$0.00	F	$35.00 / 15 min	CPT Code Description	SOAP note for 2-21-02 was not submitted to support service per MFG.
2-21-02	97112 (2 units)	$70.00	$0.00	F	$35.00 / 15 min	CPT Code Description	SOAP note for 2-21-02 was not submitted to support service per MFG.
2-21-02 3-14-02	97035	$44.00	$0.00	No EOB	$22.00 / 15 min	CPT Code Description	3-14-02 report does not support service billed, no reimbursement is recommended. SOAP note for 2-21-02 was not submitted to support service per MFG.
3-14-02	99214MP	$71.00	$0.00	F	$71.00	CPT Code Description	Report supports service per MFG, reimbursement of $71.00 is recommended.
3-14-02	97265	$43.00	$0.00	No EOB	$43.00	CPT Code Description	Report does not support service billed, no reimbursement is recommended.
3-14-02	97122 (2 units)	$70.00	$0.00	No EOB	$35.00 / 15 min	CPT Code Description	Report does not support service billed, no reimbursement is recommended.
3-14-02	99080-73	$15.00	$0.00	No EOB	$15.00	CPT Code Description	Report does not support service billed, no reimbursement is recommended.
9-5-02	97250	$43.00	$0.00	No EOB	$43.00	CPT Code Description	SOAP note for date of service was not submitted to support billed service per MFG. No reimbursement is recommended.
9-5-02	97112 (2 units)	$70.00	$0.00	F	$35.00 / 15 min	CPT Code Description	
9-5-02	97035 (2 units)	$44.00	$0.00	No EOB	$22.00 / 15 min	CPT Code Description	
10-16-02	99213MP	$48.00	$0.00	F	$48.00	CPT Code Description	
10-16-02	97250	$43.00	$0.00	F	$43.00	CPT Code Description	
10-16-02	97265	$43.00	$0.00	F	$43.00	CPT Code Description	
10-16-02	97039HE	$100.00	$0.00	M	DOP	Section 413.011(b)	

TOTAL			The requestor is entitled to reimbursement of $139.00.

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 12-13-01 through 10-16-02 in this dispute.

This Order is hereby issued this 19th day of September 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

April 14, 2003

Re: IRO Case # M5-03-0979

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas. He or she has signed a certification statement attesting that no known conflicts of interest exist between

him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case. The determination of the ___ reviewer who reviewed this case, based on the medical records provided for review, is as follows:

History
The patient was injured on ___ by repetitive typing and talking on the telephone. She has had chiropractic treatment, physical therapy, medication, injections and carpal tunnel surgery.

Requested Service(s) office visits, physical therapy 5/16/02-5/22/02

Decision
I agree with the carrier's decision to deny the requested treatment.

Rationale
The patient had extensive conservative pre-surgical treatment for carpal tunnel syndrome. Chiropractic treatment for 11 months provided little, if any, lasting relief of her symptoms. Treatment prior to the dates of service in dispute failed to be effective in relieving symptoms or improving function. The treatment in dispute was rendered knowing surgery was scheduled within one month and that similar treatment had failed to give lasting relief of the patient's symptoms.
The doctor should have realized after four to six weeks of treatment that the patient's prognosis was poor with conservative care and that prolonging surgery would not be beneficial to the patient and could complicate post surgical recovery. The documentation presented for this review failed to show why extensive treatment was reasonable and effective.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

_____