MDR: Tracking Number M5-03-1025-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 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 12-23-02.

The IRO reviewed chiropractic treatment rendered from 1-15-02 through 9-30-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
1-22-02	99213MP	$50.00	$0.00	V	$48.00	Section 408.021(a)	IRO concluded these services were medically necessary, reimbursement per MFG is recommended.

The IRO concluded that treatment prior to 2-5-02 was medically necessary. All treatment after 2-5-02 were not medically necessary.

On this basis, the total amount recommended for reimbursement ($48.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. 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.

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

On August 7, 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:

Neither party submitted EOB for services identified with "No EOB"; therefore, they will be reviewed in accordance with the *Medical Fee Guideline.*

Neither party submitted original EOBs for services identified with "O" and "P"; therefore, they will be reviewed in accordance with the *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
1-10-02	97265	$45.00	$0.00	No EOB	$43.00	CPT code descriptor	SOAP note does not support joint mobilization, reimbursement is not recommended.
1-10-02	97750FC	$500.00	$100.00	F	$100.00/hr	Medicine GR (I)(E)(2)(a)	The requestor did not note the time on FCE report; therefore, unable to recommend additional reimbursement per MFG.
1-15-02	95904 – 26% (4 nerves)	$256.00	$0.00	No EOB	$64.00/per nerve	Medicine GR (IV)(D)	"-26 modifier" has a reimbursement of 30%. The NCV report supports sensory testing of left peroneal and sural nerves = 2 nerves X $64.00 = $128.00 X 30% = $38.40.
1-15-02	95935-26	$212.00	$0.00	S, F	$53.00 per extremity	Medicine GR (IV)(B)	"-26 modifier" has a reimbursement of 30%. Report supports F-wave and H-wave studies of the lower extremities; therefore, the reimbursement = 2 f-wave and 2 H-wave = 4 X $53.00 = $212.00 X 30% = $63.60.
1-29-02	95851	$150.00	$0.00	F	$36.00	Medicine GR (I)(E)(4)	ROM report supports cervical and lumbar spine testing = 2 tests X $36.00 = $72.00.
2-13-02 2-15-02 2-26-02 3-6-02	97265	$45.00	$0.00	F	$43.00	CPT code descriptor	SOAP notes do not support joint mobilization, reimbursement is not recommended.
2-19-02	22505-26 (X2)	$600.00	$0.00	O, F	$200.00 ea.	CPT code descriptor	CPT code description states "Manipulation of spine requiring anesthesia, any region." Report supports MUA of lumbar spine; therefore, reimbursement of $200.00 X 30% = $60.00.
3-1-02	97250	$90.00	$43.00	F	$43.00	CPT code descriptor	SOAP note does not support myofascial release – no

							reimbursement is recommended.
3-1-02	99070	$30.00	$0.00	No EOB	DOP	General Instructions GR (IV)	Prescription states that analgesic cream was given to claimant. Reimbursement of $30.00 is recommended.
3-1-02	99080	$250.0 0	$0.00	F	DOP	General Instructions GR (III), (IV)	Report was not submitted to support billed service.
3-5-02	99213	$65.00	$0.00	O	$48.00	Evaluation & Management GR (IV)	SOAP note supports service billed per MFG, reimbursement of $48.00 is recommended.
3-5-02	97112	$35.00	$0.00	P	$35.00 / 15 min	CPT code descriptor	SOAP note does not support neuromuscular reeducation. No reimbursement is recommended.
3-5-02	97500	$45.00	$0.00	No EOB	$24.00	CPT code descriptor	SOAP note does not support orthotics training. No reimbursement is recommended.
3-20-02 4-10-02	99213	$65.00	$24.00	H	$48.00	CPT code descriptor	SOAP notes supports billed service, additional reimbursement of $24.00 each date X 2 = $48.00 is recommended.
3-20-02	97530	$50.00	$17.50	H	$35.00/ 15 min	CPT code descriptor	SOAP note does not support one on one patient contact, no reimbursement is recommended.
3-20-02 4-10-02	97112	$50.00	$17.50	H	$35.00/ 15 min	Medicine GR (I)(A)(9)(b)	SOAP note does not support neuromuscular reeducation, no reimbursement is recommended.
3-20-02 4-10-02	97250	$45.00	$21.50	H	$43.00	CPT Code Descriptor	SOAP note support "MR" on 3-20-02 but not on 4-10-02. Reimbursement is recommended of $21.50.
4-10-02	97265	$45.00	$21.50	H	$43.00	CPT code descriptor	SOAP notes do not support joint mobilization, reimbursement is not recommended.
4-10-02	97110	$50.00	$17.50	H	$35.00/15 min	Medicine GR (I)(A)(9)(b)	SOAP note does not support one on one supervision, no reimbursement is

							recommended.
4-5-02	99213	$65.00	$0.00	T	$48.00	HB-2600	HB2600 abolished the treatment guidelines; therefore, the insurance carrier was incorrect to utilize the treatment guidelines as basis of denial. Reimbursement of $48.00 is recommended.
6-12-02 6-14-02 6-21-02	97265(X2)	$90.00	$0.00	F	$43.00	CPT code descriptor	SOAP notes do not support joint mobilization, reimbursement is not recommended.
5-21-02 7-19-02 7-23-02	97265	$45.00	$0.00	F	$43.00	CPT code descriptor	SOAP notes do not support joint mobilization on 5=21 and 7-23, reimbursement is recommended for 7-19-02 of $43.00.
7-19-02	99215MP	$175.00	$0.00	N	$103.00	Evaluation & Management GR (IV)	Comprehensive exam report supports billed service, reimbursement per MFG is recommended of $103.00.
9-4-02	97265(X2)	$90.00	$0.00	No EOB	$43.00	CPT code descriptor	SOAP notes do not support joint mobilization, reimbursement is not recommended.
9-4-02	97530	$50.00	$0.00	No EOB	$35.00/15 min	CPT code descriptor	SOAP note does not support one on one patient contact, no reimbursement is recommended.
9-4-02	99070	$50.00	$0.00	No EOB	DOP – requestor noted that amount is $35.00	General Instructions GR (IV) and (III)	SOAP note does not support DOP, no reimbursement is recommended.
9-4-02	97750MT (2 units)	$150.00	$0.00	No EOB	$43.00 / body area	Medicine GR (I)(E)(3)	Muscle testing of spine was performed, reimbursement of $43.00 is recommended.
9-4-02	95851 (X2)	$150.00	$0.00	No EOB	$36.00	Medicine GR (I)(E)(4)	ROM report supports cervical and lumbar spine testing = 2 tests X $36.00 = $72.00.
TOTAL							The requestor is entitled to reimbursement of **$690.50**

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 1-10-02 through 9-30-02 in this dispute.

This Order is hereby issued this 2nd day of October 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 23, 2003

Re: IRO Case # M5-03-1025

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 IROs, 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, is as follows:

History

The patient injured his neck and lower back on ___ when he fell off a ladder. He was treated with ESIs, MUAs, chiropractic treatments, MRIs and a myelogram.

Requested Service(s)
Office visits /manipulations, physical therapy, range of motion 1/15/02-9/30/02

Decision
I agree with the carrier's decision to deny the requested treatment after 2/5/02. I disagree with the denial of treatment prior through 2/5/02.

Rationale
The patient received extensive conservative treatment with no permanent relief of symptoms or functional improvement. The patient is a chronic pain patient because of his lower back injury, and his condition plateaued in a diminished state as of 2/5/02. The patient's cervical spine injury was a soft tissue injury and should have responded to conservative treatment within six to eight weeks post injury, which would have been 2/5/02. All treatment, including chiropractic care, three ESIs and three MUAs failed to be of any long term benefit to the patient. From the records provided for this review, the patient's ongoing and chronic care after 2/5/02 did not appear to be producing measurable or objective improvement, and did not appear directed at progression for return to work. It also did not appear to have been provided in the least intensive and most effective setting. Eight weeks of conservative treatment was appropriate. After 2/5/02 the documentation failed to show how the disputed services were necessary.

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

Sincerely,