

MDR Tracking Number: M5-03-1056-01

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 12-20-02.

The IRO reviewed chiropractic treatment rendered from 2-8-02 through 10-11-02 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 May 2, 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 audit summaries for services identified as “No EOB”; therefore, these will be reviewed in accordance with the Commission’s *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
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7-9-02 7-17-02 8-1-02 8-9-02 8-16-02 8-23-02	97110 (4 units)	\$140.00	\$0.00	No EOB	\$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	SOAP note for 7-9-02 and 8-9-02 were not submitted to support service. The remaining notes do not support the severity of injury to support exclusive one to one therapy. Therefore, reimbursement is not recommended.
7-9-02 7-17-02 8-1-02 8-9-02 8-16-02 8-23-02	99213	\$48.00	\$0.00	No EOB	\$48.00	Evaluation & Management GR (IV)	SOAP note for 7-9-02 and 8-9-02 were not submitted to support service. The remaining notes support service per MFG. Therefore, reimbursement is recommended of 3 dates X \$48.00 = \$144.00.
7-9-02 7-17-02 7-22-02 8-1-02 8-9-02 8-16-02 8-23-02	97250	\$43.00	\$0.00	No EOB	\$43.00	CPT Code Description	SOAP note for 7-9-02, 7-22-02, and 8-9-02 were not submitted to support service. The remaining notes do support myofascial release per MFG. Therefore, reimbursement is recommended of 3 dates X \$43.00 = \$129.00.
7-9-02 7-22-02 8-1-02 8-16-02 8-23-02	97035	\$22.00	\$0.00	No EOB	\$22.00	CPT Code Description	SOAP note for 7-9-02, 7-22-01 were not submitted to support service. The remaining notes do not support ultrasound per MFG. Therefore, reimbursement is not recommended.
7-26-02	90844	\$125.00	\$0.00	No EOB	\$122.00	CPT Code Description	Report was not submitted to support psychiatric and biofeedback services; no reimbursement is recommended.
7-26-02	90900	\$90.00	\$0.00	No EOB	\$2.00 / min		
7-26-02	90906	\$90.00	\$0.00	No EOB	\$2.00 / min		
TOTAL							The requestor is entitled to reimbursement of \$273.00.

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 2-8-02 through 10-11-02 in this dispute.

This Decision and Order is hereby issued this 8th day of October 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

April 21, 2003

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

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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.

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

This patient was injured on his job when he reported a cumulative trauma injury to the low back, compounded by moving some furniture at work. He initially was treated for a low back sprain/strain by ____, who put him on a PT program. He was referred to an orthopedic surgeon, ____, who recommended NCV/EMG studies to the lower extremities. These studies indicated a possible radiculopathy at the S1 level. MRI, however, was negative for pathology. The patient was put in a work conditioning program from December 2001 through January 2002. After completing this program, he changed to his current treating doctor, who began an intense program of passive therapy and chiropractic manipulation. ____ was found to be at MMI with 5% impairment by ____ who was designated doctor on this case.

DISPUTED SERVICES

The carrier has denied medical necessity of office visits with manipulations, physical therapy and X-ray examinations as medically unnecessary from February 8, 2002 through October 11, 2002.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The patient on this case had extensive care, including active and passive care and a work conditioning program, before instituting the care of the requestor. The requestor's office notes refer to ____ as "she" and "her", but do not indicate specific progress on this case. In spite of the extensive care that was rendered, the patient did not get any better with any of the treatment, indicating either a more serious pathology than originally believed or perhaps a functional overlay to this case. Regardless, the treatment rendered is not documented as being effective and due to the fact that the case should have reached closure before the beginning of chiropractic treatment, I am unable to agree with any part of the treatment plan of the requestor.

____ 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,