MDR Tracking Number: M5-03-1072-01

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 12-27-02.

The IRO reviewed chiropractic treatment rendered from 1-24-02 to 8-23-02 that were denied based upon "V".

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
1-24-02 1-28-02 1-29-02 1-30-02 1-31-02 2-6-02 2-11-02 3-4-02 3-8-02 3-15-02 3-18-02 3-20-02 3-22-02 3-29-02 4-3-02 4-8-02 4-15-02 4-23-02 4-29-02 5-29-02 5-31-02 6-13-02 6-14-02 7-5-02 7-8-02 8-8-02 8-16-02 8-23-02	99213	$48.00	$0.00	V	$48.00	Section 408.021(a)	IRO concluded these services were medically necessary; therefore, reimbursement per MFG is recommended. (29 dates X $48.00 = $1392.00)

7-26-02	99214	$71.00	$0.00	V	$71.00	Section 408.021(a)	IRO concluded these services were medically necessary; therefore, reimbursement per MFG is recommended. ($71.00)
3-4-02 3-6-02 3-8-02 3-20-02 3-22-02 3-29-02 4-1-02 4-3-02 7-5-02 7-8-02	97530 (2 units)	$70.00	$0.00	V	$35.00 X 2 = $70.00	Section 408.021(a)	IRO concluded that 2 units were medically necessary; therefore, reimbursement per MFG is recommended. (10 dates $70.00 = $700.00)
3-15-02	97530 (1 unit)	$35.00	$0.00	V	$35.00	Section 408.021(a)	IRO concluded these services were medically necessary; therefore, reimbursement per MFG is recommended. ($35.00)
3-18-02 5-31-02 6-3-02 6-13-02 6-14-02	97530 (3 units)	$105.00	$0.00	V	$35.00 X 2 = $70.00	Section 408.021(a)	IRO concluded that 2 units were medically necessary, the 3rd 97530 was not medically necessary; therefore, reimbursement per MFG is recommended of 2 units. (5 dates $70.00 = $350.00)
TOTAL							The requestor is entitled to reimbursement of **$2548.00.**

The IRO concluded that office visits and two (2) units of therapeutic activities per each office visits (97530) were medically necessary. Documentation failed to support the medical necessity of joint mobilization, myofascial release, and therapeutic exercise. None of the special reports were made available for IRO review.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees ($2548.00). 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.

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 May 15, 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	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
7-11-02	97110 (2 units)	$70.00	$0.00	R	$35.00 / 15 min	Section 408.027(d)	The respondent did not file a TWCC-21 disputing entitlement of treatment. Therefore, the insurance carrier incorrectly denied reimbursement based upon "R". These services will be re-viewed in accordance with the MFG. The 7-11-02 report was not submitted for review; therefore, no reimbursement is recommended.
	97530 (2 units)	$70.00	$0.00	R	$35.00 / 15 min		
	99213	$48.00	$0.00	R	$48.00		
7-16-02	99455-27	$350.00	$69.60	F	DOP	Evaluation & Management GR (XXII)(A) (XXII)(D)(1)(b)	Per Ground Rule the requestor is entitled to 20% reimbursement = The HCFA-1500 does not indicate the modifier to correspond with the last digit of the office visit. The requestor tested one body area = $300.00 Therefore, the requestor did not bill in accordance with MFG, and additional reimbursement is not recommended.
TOTAL		$538.00					The requestor is not entitled to reimbursement.

This Decision is hereby issued this 15th day of October 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 1-24-02 through 8-23-02 in this dispute.

This Order is hereby issued this 15th day of October 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

May 1, 2003

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: MDR #: M5-03-1072-01
IRO Certificate No.: 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Certified in Chiropractic Medicine.

Clinical History:
This female claimant suffered work-related injuries to her head, neck and back. The patient has undergone a number of diagnostic studies

Disputed Services:
Therapeutic procedures, kinetic activities, office visits, myofascial release, joint mobilization and special reports for the period of 01/24/02 through 07/08/02 and from 07/26/02 through 08/23/02.

Decision:
The reviewer partially agrees with the determination of the insurance carrier as follows:

Medically Necessary:

- Office visits (99214, 99214)
- Two (2) units of therapeutic activities per each office visit (97530)

Not Medically Necessary:

- Myofascial release (97250)
- Special reports (99455-27)
- TWCC-73 reports (99080-73)
- Joint mobilization (97265)
- Therapeutic exercises (97110)

Rationale for Decision:
The office visits reviewed appeared to be medically necessary and in line with the expected usual and customary for this type of injury. Based on the documentation reviewed, two units of therapeutic activities were justified. Documentation fails to support the medical necessity of joint mobilization, myofascial release, and therapeutic exercises. None of the special reports were made available for review

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,