

MDR Tracking Number: M5-03-1140-01

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 1-9-03.

The IRO reviewed chiropractic treatment and somatosensory testing rendered from 1-21-02 to 4-23-02 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	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
1-21-02	97122	\$35.00	\$0.00	U	\$35.00	Section 408.021(a)	IRO concluded these services were medically necessary; therefore, reimbursement per MFG is recommended (\$275.00)
3-18-02	99213MP	\$48.00	\$0.00	U	\$48.00 (X 5 = \$240.00)		
3-26-02							
4-2-02							
4-11-02							
4-23-02							
4-17-02	95925-27	\$700.00	\$0.00	U	\$175.00		IRO concluded that testing was not medically necessary.

The IRO concluded that somatosensory testing was not medically necessary. The IRO concluded that all other services rendered were medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees (\$275.00). Therefore, upon receipt of this Order and in accordance with §133.308(r)(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 April 3, 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	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
1-17-02 1-31-02	95851	\$36.00	\$0.00	G	\$36.00	Medicine GR (I)(E)(4)	The requestor did not submit ROM report or records to support that service was not global to any other service; therefore, no reimbursement is recommended.
2-14-02	97110(X3)	\$105.00	\$0.00	F	\$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	The requestor did not submit physical therapy report to support service per MFG; therefore, no reimbursement is recommended.
2-25-02	97110(X4)	\$140.00	\$0.00	F	\$35.00 / 15 min		
TOTAL							The requestor is not entitled to reimbursement.

**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 1-21-02 through 4-23-02 in this dispute.

This Decision and Order is hereby issued this 15<sup>th</sup> day of October 2003.

Elizabeth Pickle  
 Medical Dispute Resolution Officer  
 Medical Review Division

March 14, 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 the job with \_\_\_ when she twisted her ankle on her job, causing a sprain of the left ankle. She underwent treatment to include passive and active care for the rehabilitation of the injury. MRI of the ankle revealed a sprain without significant ligamentous interruption. SSEP was performed on April 22, 2002 and was normal. This patient was found to be at MMI on April 29, 2002 with 0% impairment by the treating doctor.

#### DISPUTED SERVICES

The carrier is disputing office visits, manual traction and a somatosensory testing as medically unnecessary on January 21, 2002 as well as March 18, 2002 through April 23, 2002.

#### DECISION

The reviewer agrees with the prior adverse determination regarding the somatosensory testing and manual traction.

The reviewer disagrees with the prior adverse determination for all other disputed services.

#### BASIS FOR THE DECISION

The SSEP test was not justified for its medical necessity. This patient was very near MMI with 0% impairment when the test was performed. In fact, the MMI was granted 1 week after the test data was interpreted. There is not documentation of the concern of the doctor of why such a test would be necessary to treat this patient's injury.

The manual traction in question was performed on an acute ankle injury which was less than 1 week post-injury. Manual traction in such an injury would be contraindicated, especially considering that there was concern about ligamentous instability at this point, witnessed by MRI performed about 6 weeks later.

The remaining services rendered by the treating doctor were well documented and within good practice, per the Texas Guidelines to Quality Assurance.

\_\_\_ 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,