MDR Tracking Number: M5-03-1161-01

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 1-13-03.

The IRO reviewed chiropractic treatment, and work hardening program rendered from 1-23-02 through 6-19-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. 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. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

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 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 that were 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
1-23-02	99213	$48.00	$12.00	F	$48.00	Evaluation & Management GR (IV)	Office visit report was not submitted to support billed service per MFG. No reimbursement is recommended.
3-18-02 3-20-02 3-25-02 4-2-02 4-5-02 4-9-02	99213	$48.00	$00.00	No EOB	$48.00		

3-14-02 3-18-02 3-25-02 4-2-02 4-5-02	97265	$43.00	$0.00	No EOB	$43.00	CPT Code description	Physical therapy report was not submitted to support billed service per MFG. No reimbursement is recommended.
3-14-02 3-20-02 4-2-02 4-5-02	97250	$43.00	$0.00	No EOB	$43.00	CPT Code description	Physical therapy report was not submitted to support billed service per MFG. No reimbursement is recommended.
3-14-02 3-18-02 3-20-02 4-2-02 4-5-02	97122	$35.00	$0.00	No EOB	$35.00	CPT Code description	Physical therapy report was not submitted to support billed service per MFG. No reimbursement is recommended.
3-14-02 3-20-02	97110(X3)	$105.00	$0.00	No EOB	$35.00/ 15 min	Medicine GR (I)(A)(9)(b)	Physical therapy report was not submitted to support billed service per MFG. No reimbursement is recommended.
3-18-02 4-5-02	97110(X4)	$140.00	$0.00	No EOB	$35.00/ 15 min	Medicine GR (I)(A)(9)(b)	Physical therapy report was not submitted to support billed service per MFG. No reimbursement is recommended.
5-13-02 5-14-02	97545WH (2 hrs.)	$102.40	$0.00	No EOB	$51.20/hr	Medicine GR (II)(E)	Work Hardening reports document that

5-15-02 5-16-02 5-20-02 5-21-02 5-22-02 5-23-02 5-24-02 5-28-02	97546WH (6 hrs.)	$307.20					claimant arrived at 8:00 am and left at 4:00 pm = 8 hours. However, the requestor did not consider lunch or breaks. Therefore, reimbursement is recommended for 7 hours. 7 hours X $51.20 = $358.40 X 9 dates = $3225.60. On 5-28-02 the claimant arrived at 8:00 am and left at 2:00 pm = 6 hours. Therefore, reimbursement of 5 hours is recommended for 5-28-02 = $256.00.
5-17-02	97545WH (2 hrs.) 97546WH (6 hrs.)	$102.40 $307.20	$0.00	A	$51.20/hr	Medicine GR (II)(E)	Work Hardening was approved on 5-10-02 for 4 weeks of work hardening. Therefore, the insurance carrier incorrectly denied reimbursement based upon “A”. Work Hardening reports document that claimant arrived at 8:00 am and left at 4:00 pm = 8 hours. However, the requestor did not consider lunch or breaks. Therefore, reimbursement is recommended for 7 hours. 7 hours X $51.20 = $358.40
TOTAL							The requestor is entitled to reimbursement of **$3840.00.**

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 1-23-02 through 6-19-02 in this dispute.

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

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

May 7, 2003

Re: MDR #: M5-03-1161-01

___ 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 male patient was injured on the job on ___, twisting his left ankle. Treatment consisted of passive therapy, which progressed into an active therapeutic rehabilitation program. Following additional diagnostic testing confirming the extent of the injury, referrals were made to other providers who added medications and injections.

Disputed Services:
Office visits, manipulations, physical therapy, work hardening and medical/physical supplied during the period of 01/23/02 through 06/19/02.

Decision:
The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the requested services were medically necessary in this case.

Rationale for Decision:
In reviewing the records on each date of service, there were subjective symptoms, objective findings, as well as a specific treatment program outlined. There is sufficient documentation on each date of service to support the need for each procedure that was performed.

All denied services performed on this patient from 01/23/02 through 06/19/02, were usual, reasonable, customary and medically necessary for the treatment of this patient's injury.

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.