

MDR Tracking Number: M5-03-1299-01

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 1-27-03.

The IRO reviewed chiropractic treatment rendered from 2-6-02 through 9-10-02 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.

The IRO concluded that office visits, x-rays, therapeutic procedures, data analysis, physical performance test, myofascial release, joint mobilization, unusual travel, physical medicine treatment, range of motion testing, work hardening and office visits with manipulation were not medically necessary. The IRO concluded that manual traction on 2-15-02 was medically necessary.

On this basis, the total amount recommended for reimbursement (\$35.00) 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 May 14, 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
2/25/02	95851	\$144.00	\$0.00	F, G	\$36.00 each	Medicine GR (I)(E)(4)	Testing was not global to any service billed on this date. ROM test of the left and right shoulder and right and left knee supports billed service, reimbursement of \$144.00 is recommended.
2/27/02	95851	\$72.00	Testing was not global to any service billed on this date. ROM test of the cervical and lumbar spine supports billed service, reimbursement of \$72.00 is recommended.				
3/13/02	95851	\$108.00	Testing was not global to any service billed on this date. ROM test of the left and right shoulder and right knee supports billed service, reimbursement of \$108.00 is recommended.				
3/8/02	97122	\$35.00	\$0.00	G, F	\$35.00		Physical therapy service is not global to any service billed on this date. SOAP note supports billed service, reimbursement of \$35.00 is recommended.
TOTAL		\$359.00					The requestor is entitled to reimbursement of \$359.00.

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 2-6-02 through 9-10-02 in this dispute.

This Decision and Order is hereby issued this 3rd day of November 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

CORRECTED NOTICE OF INDEPENDENT REVIEW DECISION

May 20, 2003

Re: IRO Case # M5-03-1299-01

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 was injured on ___ when he was riding in the back of a truck picking up road markers. The truck was struck by another vehicle, and he was thrown out of the truck and fell on to the pavement. The cones in the truck then hit him in the face and back.

Requested Service

Office visits, x-rays, therapeutic procedures, data analysis, physical performance test, myofascial release, joint mobilization, unusual travel, physical medicine treatment, range of motion, work hardening, office visits with manipulation 2/6/02-9/10/02.

Decision

I agree with the carrier's decision to deny the requested treatment, except for Manual traction (97122) and on 2/15/02. I disagree with the denial of manual traction on 2/15/02.

Rationale

The patient received extensive chiropractic treatment and testing for the injury. It is documented that x-rays were taken at the ER after the accident. No reason is suggested of why the treating doctor needed to take x-rays, when the x-rays from the ER could have been obtained upon request. If the x-rays were not previously taken at the ER, then they would be reasonable and necessary.

Code 99213 on 4/16/02 and 6/14/02 is not necessary based on lack of documentation presented to support necessity. Treatment must be reasonable and effective in relieving symptoms or improving function, and in this case, two months after treatment was initiated, no documented evidence was presented that treatment was beneficial to the patient. The lumbar ROM studies (95851) were unnecessary, as the documentation does not support the need for such extensive testing. Codes 99213 on 4/16/02 and 99213MP on 6/14/02 were unnecessary as the documentation for these dates is the same as the documentation for every other date, and does not support the need for the treatment. A complex history and examination of high complexity, (99205) on 2/6/02 is not necessary and is not supported by the documentation presented for this review.

The patient was found to be at MMI on 6/20/02. After an MMI date is reached, all further treatment must be reasonable and effective in relieving symptoms or improving function. Range of motion and pain scale documentation fail to show that the patient was improving four months after treatment was initiated. The doctor 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,