THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-1808.M5

MDR Tracking Number: M5-03-1360-01

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 1-30-03.

The IRO reviewed chiropractic treatment rendered from 5-1-02 through 7-23-02 that were denied based upon "V".

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 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
3-4-02 3-28-02 4-15-02 5-20-02	99213	$48.00	$0.00	L	$48.00	Rule 126.9	The treating doctor, ___is part of ___; therefore, the respondent incorrectly denied reimbursement based upon "L." SOAP notes supports billed service per MFG, reimbursement of 4 dates X $48.00 = $192.00.
4-8-02	99213	$48.00	$0.00	N	$48.00	Evaluation & Management GR (IV)	SOAP note documentation supports billed service per MFG, reimbursement of $48.00 is recommended.
4-22-02	95851	$36.00	$0.00	No EOB	$36.00/ each	Medicine GR (IV)	ROM report supports billed service per MFG, reimbursement of $36.00 is recommended.
4-29-02	97122	$35.00	$0.00	No EOB	$35.00	CPT Code Descriptor	SOAP note documentation supports billed service per MFG, reimbursement of $35.00 is recommended.
TOTAL							The requestor is entitled to reimbursement of **$311.00.**

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 3-4-02 through 7-23-02 in this dispute.

This Decision and Order is hereby issued this 12th day of November 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 20, 2003

Re: IRO Case # M5-03-1360-01

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 physician who is Board Certified in Physical Medicine and Rehabilitation. 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 is a 45-year-old male who was injured on ___ when he fell about four feet, landing on his left buttock. He was unable to walk and taken to the ER. X-rays showed a fracture of the neck of the left femur. The patient underwent surgical

repair, and was treated post operatively with extensive physical therapy and chiropractic visits. He was also treated with a shoe lift for leg length discrepancies. Because of continued pain, the patient underwent hardware removal 3/21/02. He returned to his chiropractor for continued therapy and chiropractic treatments.

Requested Service
Office visits, therapeutic procedures, myofascial release, joint mobilization, neuromuscular re-education, data analysis, physical therapy, physical performance test 5/1/02-7/23/02

Decision
I agree with the carrier's decision to deny the requested treatment.

Rationale
The patient fractured his left hip on ___. He was treated with surgical repair and subsequent hardware removal. Following both surgeries he was treated extensively by a chiropractor with physical therapy and chiropractic treatment for months after surgery. Throughout the treatments in dispute the patient was noted to complain of pain on a level of 3 out of 10 without much variation. There is no documentation showing that his therapy was beneficial. There is no documentation in any of the notes provided for this review stating the medical necessity for continued physical therapy for this duration. Physical therapy beyond one month after surgery would not be medically necessary or appropriate, and chiropractic treatment for a fractured hip would also not be medically necessary or appropriate.
.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,