

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 2-10-03.

The IRO reviewed office visits, supplies, special reports, physical therapy, range of motion, physical performance testing rendered from 4-15-02 through 4-24-02 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 joint mobilization (97265) and electric stimulation (97014) were not medically necessary. The IRO concluded that all other treatments were medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees. 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 June 12, 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
4-4-02	99205	\$160.00	\$0.00	L	\$137.00	Rule 126.9	On 4-9-02, TWCC approved the request to change treating doctors from ___ to ___. Therefore, the insurance carrier appropriately denied reimbursement based upon “L.”

4-4-02	99070	\$18.33 \$8.00	\$0.00	L	DOP	Rule 126.9	On 4-9-02, TWCC approved the request to change treating doctors from ___ to ___. Therefore, the insurance carrier appropriately denied reimbursement based upon "L."
4-4-02	99080-61	\$70.00	\$0.00	L	See Rule 133.106(f)(2)	Rule 126.9	
4-8-02 4-10-02 4-12-02 5-2-02	99213	\$50.00	\$0.00	N	\$48.00	Evaluation & Management GR (IV)	Office visit report documentation supports service billed. Reimbursement of 4 dates X \$48.00 = \$192.00.
4-8-02 4-10-02 4-12-02	97265	\$43.00	\$0.00	N	\$43.00	CPT Code Descriptor	SOAP note documents service billed, reimbursement of 3 dates X \$43.00 = \$129.00.
4-8-02 4-10-02 4-12-02	97250	\$43.00	\$0.00	N	\$43.00	CPT Code Descriptor	SOAP note documents service billed, reimbursement of 3 dates X \$43.00 = \$129.00.
4-8-02	97110 (X4)	\$140.00	\$0.00	N	\$35.00 / 15 min	CPT Code Descriptor	Therapeutic exercise documents service per MFG, reimbursement of \$140.00 is recommended.
4-8-02 4-10-02 4-12-02	97014	\$17.00	\$0.00	N	\$15.00	CPT Code Descriptor	SOAP note documents service billed, reimbursement of 3 dates X \$15.00 = \$45.00.
4-10-02	97110 (X7)	\$245.00	\$0.00	N	\$35.00 / 15 min	CPT Code Descriptor	Therapeutic exercise documents service per MFG, reimbursement of \$245.00 is recommended.
4-12-02	97110 (X8)	\$280.00	\$0.00	N	\$35.00 / 15 min	CPT Code Descriptor	Therapeutic exercise documents service per MFG, reimbursement of \$280.00 is recommended.
5-1-02	99215	\$125.00	\$0.00	N	\$103.00	Evaluation & Management GR (IV)	Office visit report documents level of service billed, reimbursement of \$103.00 is recommended.
5-1-02	99080-73	\$15.00	\$0.00	N	\$15.00	Rule 129.6(d)	TWCC-73 documents service billed, reimbursement of \$15.00 is recommended.
5-1-02 5-7-02	97750MT	\$172.00 \$258.00	\$0.00	N	\$43.00/ body area	Medicine GR (I)(E)(3) and (I)(D)	Lumbar muscle testing report supports 1 body area tested; therefore, reimbursement of \$43.00 X 2 dates = \$86.00.
TOTAL							The requestor is entitled to reimbursement of \$1364.00.

This Decision is hereby issued this 17<sup>th</sup> day of November 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 4-4-02 through 5-7-02 in this dispute.

This Order is hereby issued this 17<sup>th</sup> day of November 2003.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

April 15, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M5.03.1435.01  
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 her job with the \_\_\_ while working as a \_\_\_ when records indicate that she was sitting in a chair and it slipped from under her, causing a fall that injured her head,

right shoulder and low back. Initially she was treated by \_\_\_ and received PT from \_\_\_ at \_\_\_. She requested a change of doctors on April 4, 2002 and began treatment under the direction of \_\_\_. He initiated a program of aggressive active and passive care for the patient. \_\_\_ found the patient to be at MMI with 0% impairment on February 4, 2002.

#### DISPUTED SERVICES

The carrier has denied medical necessity of office visits, supplies, special reports, physical therapy, range of motion and physical performance testing from April 15, 2002 through April 24, 2002.

#### DECISION

The reviewer agrees with the prior adverse determination regarding joint mobilization and electrical stimulation.

The reviewer disagrees with the prior adverse determination for all other treatment rendered on the dates in question.

#### BASIS FOR THE DECISION

Joint mobilization is a form of manipulation which is considered to be included in the basic office service of the chiropractic doctor. No records exist that indicate a service above and beyond the manipulative therapy should be considered necessary. Electrical stimulation is not demonstrated to be effective at this point in the patient's treatment plan, and passive therapy would not be medically necessary under normal circumstances. No documentation exists to indicate this case would be an exception.

The remainder of the treatment is documented as being reasonably expected to help this patient return to a productive work environment. Active treatment is well documented in this case as being effective in this particular case and the patient was responding well to the care.

\_\_\_ 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,