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

SOAH DOCKET NO. 453-04-2025.M5

MDR Tracking Number: M5-03-1477-01

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 2-13-03.

Dates of service prior to 2-13-02 were submitted untimely per above referenced Rule.

The IRO reviewed office visits and physical therapy sessions rendered from 3-4-02 through 7-31-02 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 20, 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 insurance carrier submitted missing EOBs on 6-18-03. These EOBs were submitted after the case was forwarded to IRO, IRO decision was made, and 14 day letter was issued. Therefore, since these EOBs were submitted untimely, services will be reviewed based upon "No EOB."

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
2-14-02 2-18-02 2-19-02 2-21-02 2-25-02 2-27-02 2-28-02	99213MP	$68.00	$0.00	No EOB	$48.00	Medicine GR (I)(B)(1)(b)	SOAP note supports billed service per MFG, reimbursement of 7 dates X $48.00 = $336.00.
2-14-02 2-18-02 2-19-02 2-21-02 2-25-02 2-27-02 2-28-02	97110 (X3)	$147.00	$0.00	No EOB	$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	SOAP note does not document 1 to 1 supervised treatment per MFG. No reimbursement is recommended.
2-14-02 2-18-02 2-19-02 2-21-02 2-25-02 2-27-02 2-28-02	97035	$31.00	$0.00	No EOB	$22.00	CPT Code description	SOAP note supports billed service per MFG, reimbursement is recommended of 7 dates X $22.00 = $154.00.
TOTAL							The requestor is entitled to reimbursement of **$490.00.**

This Decision is hereby issued this 20th 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 2-14-02 through 7-31-02 in this dispute.

This Order is hereby issued this 20th day of November 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

May 16, 2003

Re: MDR #: M5-03-1477-01

CORRECTED 05/20/03 UNDER "DECISION" THE CORRECT DATE IS 07/31/02 NOT 07/31/2 PER REQUEST OF CAROL LAWRENCE.

___ 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:
On ___ this 52-year-old male injured his right ankle/knee. A comminuted fracture of the right lateral malleoulus was casted on 06/21/00. MRI of the right ankle on 10/06/00 revealed tendinosis, partial tear of the talofibular and calcaneofibular ligaments.

MRI of the right knee on 03/21/01 indicated posterior horn/body portion, 3-4 mm degenerative oblique linear partial tear. MRI of the right knee on 05/22/02 showed lateral meniscus anterior horn 2-3 mm horizontal linear tear.

On 01/18/01 the patient had an open arthrotomy of the right ankle. Further, surgical applications to repair the right ACL, right medial meniscus, and chondromalacia of patella were performed on 10/30/00.

Physical therapy and chiropractic therapeutics were initiated on 11/13/00 and the patient was placed at maximum medical improvement (MMI) on 08/15/02 and was assigned a 12% whole-body impairment.

Disputed Services:
Denial of office visits and physical therapy applied from 03/04/02 through 07/31/02.

Decision:
The reviewer disagrees with the determination of the insurance carrier. Office visits and physical therapy applied from 03/04/02 through 07/31/02 were medically necessary.

Rationale:
Medical records reviewed show a severe crushing injury that would require a complete course of physical therapy applications. Review of the provider's treatment shows a trend toward active, patient-driven therapeutics, which was appropriate. The management of this patient was lengthened by a premature return to work without obtaining all necessitated diagnostics and appropriate specialty referrals.

The patient must continue with rehabilitation applications and be directed into a multi-disciplinary return-to-work program like work hardening to facilitate a return to gainful employment.

The aforementioned information has been taken from the following clinical references:

A.A.O.S. Clinical Guidelines on Knee Injuries: Support Document. American Academy of Orthopedic Surgeons, 2001, 6 p.

Ankle Sprain. Institute for Clinical Systems Improvement, I.C.S.I., 2002, Mar., 24 p.

Clinical Guideline on Ankle Injury. American Academy of Orthopedic Surgeons, 1997, 7 p.

Criteria for Ankle/Foot. Washington State Department of Labor and Injuries, 1999, Jun. 2 p.

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.

Sincerely,