MDR Tracking Number: M5-03-2316-01

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, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 12-18-02.

The IRO reviewed office visits, data analysis, electrical stimulation, NCV study, physician team conference, myofascial release, supplies, muscle testing, diathermy, therapeutic activities, special reports, physician education services, paraffin, and electrodes rendered from 12/26/01 to 12/28/01, 2/11-12/02, 4/23/02 to 7/23/02 that were denied as unnecessary medical.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO has determined that the above services rendered from 12-26-01 through 2-12-02 were medically necessary. The IRO agrees with the previous determination that the above rendered from 4-23-02 through 7-23-02 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the 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 August 26, 2003, the Medical Review Division submitted a Notice to the 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
2/1/02	K0118	85.00	0.00	C	DOP	96 MFG DME GR X C	Carrier denied as "C – negotiated contract price. Requestor did not challenge carrier's

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
							denial rationale. Neither party submitted a copy of the negotiated contract. No reimbursement recommended.
2/7/02	99070	60.00	0.00	C	DOP	96 MFG GI III A; IV	Carrier denied as "C – negotiated contract price. Requestor did not challenge carrier's denial rationale. Neither party submitted a copy of the negotiated contract. Relevant information was not submitted to support service rendered. No reimbursement recommended.
2/18/02 to 4/19/02	97545WH 97546WH	128.00 x 30 192.00 x 30	0.00	V	64.00/hr minus 20% reduction for Non-CARF	134.600 (h) (9); 96 MFG Med GR II E 3-5	Carrier denied as "V"; however, requestor submitted preauthorization approval letter dated 2/13/02 for four weeks of a WH program and a subsequent approval letter dated 3/20/02 for an additional 20 sessions. Therefore, this review will be per the MFG only. Weekly Patient Progress Work Hardening Reports for weeks one through seven do not support number of hours billed. No reimbursement

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
							recommended.
7/29/02	97014	20.00	0.00	T	15.00	Advisory 2002-11; Rule 133.1(a)(12); 133.304(C)	Carrier denied as "T – outside of treatment guidelines". The treatment guidelines were abolished by statute effective 1/1/02; therefore, this review will be per the MFG. Office note dated 7/29/02 supports service rendered. Recommend reimbursement of $15.00.
TOTAL		9765.00	0.00				The requestor is entitled to reimbursement of $15.00.

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 Order is applicable for dates of service 12-26-01 through 7-29-02 in this dispute.

This Order is hereby issued this 9th day of January 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

January 7, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: MDR # M5-03-2316-01
IRO Certificate No.: IRO 5055

REVISED REPORT
Revisions to services in dispute.

___ 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 female claimant injured her left ankle on the lateral aspect in a work-related accident on ___. She received intensive, conservative care that included passive therapy, active therapy, medication, injections, as well as a work hardening program. She responded to care, but continued to have residual problems.

Disputed Services:
Data analysis, office visits, electrical stimulation, NCV, physician team conference, myofascial release, supplies, muscle testing, diathermy, therapeutic activities, special reports, physician education services, paraffin, analgesic balm, and electrodes during the periods of 12/26/01 thru 12/28/01, 02/11/02 and 02/12/02, 04/23/02 thru 07/23/02.

Decision:
The reviewer partially agrees with the determination of the insurance carrier and is of the opinion that the services and treatments rendered from 12/26/01 thru 12/28/01, 02/11/02 and 02/12/02 were medically necessary. Other services and treatments rendered during the period of 04/23/02 thru 07/23/02 were not medically necessary in this case.

Rationale:
The patient had an aggressive treatment program that included primary, secondary, and tertiary levels of care over a period of approximately one year. The records indicate progression; however, there was a continuation of problems.

National treatment guidelines allow for passive therapy, with progression to active therapy, as well as progression into a work hardening program. Such is the case with this patient. All treatment and services rendered through the conclusion of the work hardening program on 04/19/02 were reasonable, customary and medically necessary for the treatment of this injury. However, all additional services rendered from 04/23/02 through 07/23/02 were not usual, customary or medically necessary.

According to Texas Labor Code 408:021(a), an employee is entitled to the care reasonably required in association with their injury and the treatment thereof. If the patient's condition is not stable, the care to maintain and promote healing is medically necessary.

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,