

MDR Tracking Number: M5-03-2618-01

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. The dispute was received on 6/16/03.

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.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

### I. DISPUTE

Whether there should be reimbursement for office visits 99213, joint mobilization 97265, therapeutic activity 97530, hot or cold packs 97010, medical reports 99080-73, massage 97124, manual traction 97122 and physical performance test 97750 from 6/28/02 through 12/11/02.

### II. RATIONALE

The disputed services from 6/28/02 through 8/14/02 including office visits 99213, joint mobilization 97265, therapeutic activity 97530, hot or cold packs 97010, medical reports 99080-73, massage 97124, manual traction 97122 and physical performance test 97750 were initially denied by the respondent for "E" – lack of entitlement on 8/19/02. This decision by the carrier was based upon a non-compensable shoulder diagnosis being included in the bills submitted by the requestor. The non-compensable shoulder diagnosis was removed from the bills and the requestor resubmitted the bills to the carrier. On 1/3/03, the carrier issued EOBs stating the services from 6/28/02 through 8/14/02 would be paid per contract. Per the requestor, there is no PPO contract in place and payment has not been issued. The documentation submitted by the requestor supports delivery of service to the compensable areas. Reimbursement per the 1996 Medical Fee Guideline is recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Rece	Rationale
6/28/02 thru 8/14/02	97124 x 34 units @ \$28.00 per unit.	\$952.00	0.00	E,C	\$28.00 per unit.	1996 Medical Fee Guideline CPT descriptors	Initially denied by the respondent for "E" – lack of entitlement on 8/19/02. This decision by the carrier was based upon a non-compensable shoulder diagnosis being included in the bills submitted by the requestor. The non-

							compensable shoulder diagnosis was removed from the bills and the requestor resubmitted the bills to the carrier. On 1/3/03, the carrier issued EOBs stating the services from 6/28/02 through 8/14/02 would be paid per contract. Per the requestor, there is no contract in place and payment has not been issued. The documentation submitted by the requestor supports delivery of service to the compensable areas. Reimbursement of \$952.00 is recommended.
6/28/02 thru 8/14/02	99213 x 17 units @ \$48.00 per unit.	\$816.00	0.00	E,C	\$48.00 per unit.	§133.1(a)(8)	Same as above. Reimbursement of \$816.00 is recommended.
6/28/02 thru 8/14/02	97265 x 18 units @ \$43.00 per unit.	\$774.00	0.00	E,C	\$43.00 per unit.	§133.1(a)(8)	Same as above. Reimbursement of \$774.00 is recommended.
6/28/02 thru 8/14/02	97032 x 7 units @ \$22.00 per unit.	\$154.00	0.00	E,C	\$22.00 per unit.		Same as above. Reimbursement of \$154.00 is recommended.
6/28/02 thru 8/14/02	97035 x 7 units @ \$22.00 per unit	\$154.00	0.00	E,C	\$22.00 per unit.		Same as above. Reimbursement of \$154.00 is recommended.
6/28/02 thru 8/14/02	99080-73 x 3 units @ \$15.00 per unit.	\$45.00	0.00	E,C	\$15.00 per unit.		Same as above. Reimbursement of \$45.00 is recommended.
6/28/02 thru 8/14/02	97530 x 11 units @ \$35.00 per unit.	\$385.00	0.00	E,C	\$35.00 per unit.		Same as above. Reimbursement of \$385.00 is recommended.
6/28/02 thru 8/14/02	97024 x 3 units @ \$21.00 per unit.	\$63.00	0.00	E,C	\$21.00 per unit.		Same as above. Reimbursement of \$63.00 is recommended.
6/28/02 thru 8/14/02	97122 x 1 unit @ \$35.00 per unit.	\$35.00	0.00	E,C	\$35.00 per unit.		Same as above. Reimbursement of \$35.00 is recommended.
6/28/02	99212 x 1	\$32.00	0.00	E,C	\$32.00 per unit.		Same as above.

thru 8/14/02	unit @ \$32.00 per unit.						Reimbursement of \$32.00 is recommended.
TOTAL		\$3,410.00					The requestor is entitled to reimbursement of <b>\$3,410.00</b> .

Services from 8/15/02 through 12/11/02 were denied by the carrier as not medically necessary. The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits 99213, joint mobilization 97265, therapeutic activity 97530, hot or cold packs 97010, medical reports 99080-73, massage 97124, manual traction 97122 and physical performance test 97750 from 8/15/02 through 12/11/02 medically necessary were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity was the only issue to be resolved for all services from 8/15/02 through 12/11/02. The office visits 99213, joint mobilization 97265, therapeutic activity 97530, hot or cold packs 97010, medical reports 99080-73, massage 97124, manual traction 97122 and physical performance test 97750 were found to not be medically necessary. The respondent raised no other issues for denying reimbursement for the services from 8/15/02 through 12/11/02.

On this basis, the total amount recommended for reimbursement \$3,410.00 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.

### III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for the disputed services from 6/28/02 through 8/14/02 including office visits 99213, joint mobilization 97265, therapeutic activity 97530, hot or cold packs 97010, medical reports 99080-73, massage 97124, manual traction 97122 and physical performance test 97750 in the amount of **\$3,410.00**. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **\$3,410.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 5<sup>th</sup> day of December 2003.

Noel L. Beavers  
Medical Dispute Resolution Officer  
Medical Review Division

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/nlb

October 30, 2003

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

MDR Tracking #: M5-03-2618-01  
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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). 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

The patient was moving cleaning equipment from one shelf to another and it became stuck. He pulled hard on the equipment and felt pain in the thoracic spine. He noted a "pop" in the mid-back region. He initially was seen at \_\_\_ and began treatment on June 27, 2002 by \_\_\_. Care consisted of passive therapy and chiropractic manipulation initially, later changing to a combination of passive and some active care. Peer review by \_\_\_ indicated that a reasonable amount of care would have been no more than 18 office visits with therapy. The diagnosis rendered by the providers in charge of the case is a thoracic sprain/strain and a shoulder sprain. The records indicate that the TWCC found the shoulder to be a compensable part of the injury in November of 2002. MMI was assessed by designated doctor \_\_\_ who rated the patient with 5% whole person impairment. The treating doctor on the case also rated this as 5% impairment and agreed with the date of MMI being December 11, 2002.

#### DISPUTED SERVICES

Under dispute is the medical necessity of office visits, joint mobilization, therapeutic activity, hot or cold packs, medical reports, massage, manual traction and physical performance testing from 8/15/02 through 12/11/02.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

The office notes by the requestor do not indicate the reason for extensive care that was rendered on this patient. While the \_\_\_ reviewer does not find that all sprain/strain injuries should be either more than or less than a pre-set number of visits, as the carrier's reviewer suggests, the reviewer feels that the case was documented by the requestor but not adequately enough to indicate the patient's progress or condition. The notes describe what was done and what was found, but not the patient response.

There is no “Outcome Study”, pain scale or other method of determining the patient’s response to the care. As a result, the reviewer is unable to validate the ongoing care that was rendered in this case and as a result must find the care was neither reasonable or necessary.

\_\_\_ 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,