MDR Tracking Number: M5-03-2984-01

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 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 July 17, 2003.

The IRO reviewed therapeutic exercises, temperature gradient studies, neuromuscular stimulator, office visits, joint mobilization, myofascial release, manual traction, range of motion rendered from 1/27/03 through 4/12/03 denied by the carrier based on “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.

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 September 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.

Both the requestor and respondent failed to submit copies of EOBs, therefore the disputed dates of service without EOBs will be reviewed according to the Medical Fee Guideline.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
1/27/03	98551	$36.00	$0.00	No EOB	NONE	MFG, General Instructions Ground Rule (I)(B)	Per the General Instructions Ground Rule; “Using the listed codes and ground rules, the HCP selects the name of the service or procedure that most accurately identifies each service performed…” CPT code 98551 is not a recognized

							CPT code listed on the 1996 Medical Fee Guidelines. Therefore, the requestor is not entitled to reimbursement of the disputed charge.
2/5/03	99213	$48.00	$0.00	No EOB	$48.00	MFG, Evaluation/ Management Ground Rule (VI)(B)	The requestor failed to submit relevant information to support delivery of service. The requestor, is therefore, not entitled to reimbursement of the dispute charges.
	97265	$43.00	$0.00	No EOB	$43.00	MFG, Medicine Ground Rule (I)(A)(10)(a) & (I)(C)(3)	
	97122	$35.00	$0.00	No EOB	$35.00	MFG, Medicine Ground Rule (I)(A)(9)(b) & (I)(A)(10)(a)	
	97250	$43.00	$0.00	No EOB	$43.00	MFG, Medicine Ground Rule (I)(A)(10)(a) & (I)(C)(3)	
	97110	$175.00	$0.00	No EOB	$35.00/unit	MFG, Medicine Ground Rule (I)(A)(9)(b), (I)(A)(10)(a) & (I)(A)(11)(a)	
	A4558	$18.00	$0.00	No EOB	DOP	MFG, General Instructions Ground Rule (III) & (VI) CPT code descriptor	
3/4/03	95851	$36.00	$0.00	No EOB	$36.00	MFG, Medicine Ground Rule (I)(E)(3)(4)	Review of the "F.O.C.U.S. Custom Report", dated 3/4/03 supports delivery of service, therefore the requestor is entitled to reimbursement in the amount of $36.00.
3/18/03	95851	$36.00	$0.00	No EOB	$36.00	MFG, Medicine Ground Rule (I)(E)(3)(4)	Review of the "F.O.C.U.S. Custom Report", dated 3/18/03 supports delivery of service, therefore the requestor is entitled to reimbursement in the

							amount of $36.00.
TOTAL		$470.00	$0.00		$416.00		The requestor is entitled to reimbursement of $72.00.

This Decision is hereby issued this 29th day of January 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

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 1/27/03 through 4/12/03 in this dispute.

This Order is hereby issued this 29th day of January 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

MQO/mqo

September 19, 2003

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

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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

___ was employed by ___. He had been working for this company for approximately one year when he injured his low back on ___ in a fall at work. He was treated with medications, physical therapy, manipulation and exercise therapy. On 5/19/03 the patient was rated at MMI with a zero percent impairment.

DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic exercises, temperature gradient studies, neuromuscular simulation, office visits, joint mobilization, myofascial release, manual traction therapy and range of motion testing from 1/27/03 through 4/12/03.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

Utilizing the Texas Guidelines for the Chiropractic Quality Assurance and Practice Parameters, it is found that the disputed care was medically necessary. The records reviewed, both objective and subjective, demonstrated an improving response to the treatments in question in this case. Utilizing the Texas Guidelines as a guide in the modes of care and frequency and duration of care, with the outcomes associated with this case would make this both clinically and medically necessary 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,