

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 IRO reviewed chiropractic treatment and diagnostic studies rendered from 7-9-01 to 8-8-01 that were denied based upon "T".

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.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS\$ (Maximum Allowable Reimbursement)	Reference	Rationale
7-11-01	73620WP	\$40.00	\$0.00	T	\$39.00	Section 408.021(a)	IRO concluded these services were medically necessary; therefore reimbursement of \$221.00 is recommended.
	99213	\$48.00	\$0.00	V	\$48.00		
7-11-01	97265	\$43.00	\$0.00	T	\$43.00		
7-11-01	97010	\$11.00	\$0.00	T	\$11.00		
7-11-01	97032	\$44.00	\$0.00	T	\$22.00/15 min		
7-30-01	95851	\$36.00	\$0.00	T	\$36.00		
TOTAL		\$222.00					The requestor is entitled to reimbursement of \$221.00 .

The IRO concluded that all remaining services provided were not medically necessary.

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

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
7-9-01 7-10-01 7-11-01	99082	\$17.00	\$0.00	A	DOP	Rule 134.600(h) General Instructions GR (III)	Unusual Travel does not require preauthorization. The insurance carrier was incorrect to deny reimbursement based upon not preauthorized. Documentation to support billing was not submitted. Reimbursement is not recommended.
7-9-01	99204MP	\$106.00	\$0.00	A	\$106.00	Rule 134.600(h)	Office visits do not require preauthorization; therefore, the insurance carrier was incorrect to deny reimbursement based upon not preauthorized. Documentation supports billed service, reimbursement of \$106.00 is recommended.
7-9-01	99070	\$18.00	\$0.00	A	DOP	Rule 134.600(h)(13)	Preauthorization is required for DME items in excess of \$500.00; therefore, the insurance carrier was incorrect to deny reimbursement based upon not preauthorized. Documentation to support billing was not submitted. Reimbursement is not recommended.
7-10-01	99213MP	\$75.00	\$0.00	A	\$48.00	Medicine GR (I)(B)(1)(b) Rule 134.600(h)(11)	Office visits do not require preauthorization; therefore, the insurance carrier was incorrect to deny reimbursement based upon not preauthorized. Documentation supports billing. Reimbursement is recommended of \$48.00.
7-9-01	97032	\$44.00	\$0.00	A	\$22.00	CPT code description Rule 134.600(h)(10)	The claimant was injured on 6-30-01. Preauthorization is required for physical therapy after the initial eight weeks. The disputed service falls within the initial eight weeks and does not require preauthorization. Therefore, the insurance carrier was incorrect to deny reimbursement based upon not preauthorized. Documentation supports billed service, reimbursement of \$44.00 is recommended.
7-9-01	97010	\$11.00	\$0.00	A	\$11.00	Rule	The claimant was injured on ____.

7-10-01					134.600(h)(10)	<p>Preauthorization is required for physical therapy after the initial eight weeks. The disputed service falls within the initial eight weeks and does not require preauthorization. Therefore, the insurance carrier was incorrect to deny reimbursement based upon not preauthorized.</p> <p>Documentation supports billed service, reimbursement of \$11.00 X 2 = \$22.00 is recommended.</p>
TOTAL		\$351.00				The requestor is entitled to reimbursement of \$282.00 .

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay \$503.00 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 to dates of service 09/21/01 through 06/21/02 in this dispute.

This Order is hereby issued this 18th day of July 2003.

Elizabeth Pickle
 Medical Dispute Resolution Officer
 Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

November 13, 2002

Rosalinda Lopez
 Program Administrator
 Medical Review Division
 Texas Workers Compensation Commission
 4000 South IH-35, MS 48
 Austin, TX 78704-7491

RE: MDR Tracking #: M5-02-2925-01
 IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents

utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

This 21 year old female sustained a work related injury on ___ when a heavy object fell on her right foot. The patient was evaluated and began chiropractic treatments on 07/09/01. On 07/12/01 a cast was applied to the right foot and ankle. The patient remained in a cast from 07/12/01 through 07/30/01. The patient received chiropractic care in the form of office visits with manipulation, x-ray examination of the ankle, range of motion, joint mobilization, therapeutic exercises, muscle testing, electrical stimulation, hot or cold packs, and x-ray examination of the foot.

Requested Service(s)

Office visits with manipulation (99213-MP), x-ray examination of the ankle (73600-WP), range of motion (95851), joint mobilization (97265), therapeutic exercises (97110), muscle testing (97750), electrical stimulation (97032), hot or cold packs (97010), unusual physician travel (99092), and x-ray examination of the foot (73620-WP). Dates of service in question were 07/11/01, 07/26/01, 07/30/01, and 08/08/01.

Decision

It is determined that the following services were medically necessary to treat this patient's condition: X-ray examination of the foot (73620-WP), joint mobilization (97265), hot/cold packs (97010) and electrical stimulation (97032) on 07/11/01 and ankle range of motion (95851), on 07/30/01.

It is determined that the following services were not medically necessary to treat this patient's condition:

Spinal manipulation (99213-MP) and unusual physician travel (99092) on 07/11/01; spinal manipulation (99213-MP), joint mobilization (97265), therapeutic exercises (97110), and muscle testing (97750-MT), on 07/26/01; and the spinal manipulation (99213-MP) and radiographs of the ankle (73600-WP) on 08/08/01.

Rationale/Basis for Decision

Following a work related injury on ___, this patient was seen by a chiropractor on 07/09/01. The x-ray of the foot and ankle were appropriate. On 07/12/01 an orthopedic surgeon applied a cast to the right foot and ankle. The cast remained in place until 07/30/01.

The x-ray evaluation of the foot (73620-WP) on 07/11/01 was medically necessary for the analysis of the patient's condition. The 07/11/01 treatment of the patient with joint mobilization, hot/cold packs and electrical stimulation was medically necessary for treatment of the ankle injury. The use of manipulation (99213-MP) was not medically necessary as this treatment was directed to the cervical and thoracic regions, which were not part of the patient's injury. The unusual physician travel (99082) noted on 07/11/01 was not medically necessary as no documentation supporting the use of this code was noted corresponding to the date of service in question.

The treatments administered on 07/26/01 were not medically necessary. The patient's injured body part was in a cast on that date of service. Therefore, spinal manipulation (99213-MP), joint mobilization (97265), therapeutic exercises (97710) and muscle testing (97750-MT) could not have been applied to the patient's injured body part.

The use of the range of motion study (95851) on 07/30/01 was medically necessary, as this study was done as part of the evaluation after the patient was taken out of the cast.

The treatments administered on 08/08/01 consisting of spinal manipulation to the cervical and thoracic region were not medically necessary, as this was a region unrelated to the work injury. The x-ray series of the ankle (73600-WP) was not medically necessary, as the records indicated that the patient was x-rayed to rule out calcaneal spurs, which would have been imaged on the foot series taken on 07/11/01.

Therefore, the X-ray examination of the foot (73620-WP), joint mobilization (97265), hot/cold packs (97010) and electrical stimulation (97032) on 07/11/01 and ankle range of motion (95851), on 07/30/01 were medically necessary to treat this patient's condition.

However, the spinal manipulation (99213-MP) and unusual physician travel (99092) on 07/11/01; spinal manipulation (99213-MP), joint mobilization (97265), therapeutic exercises (97110), and muscle testing (97750-MT), on 07/26/01; and the spinal manipulation (99213-MP) and radiographs of the ankle (73600-WP) on 08/08/01 were not medically necessary to treat this patient's condition.

Sincerely,