

MDR Tracking Number: M5-02-2962-01

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 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.

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. There are unresolved fee issues.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Max. Allowable Reimbursement)	Reference	Rationale
7/13/01	97750-MT	\$172.00	43.00	F	\$ 43.00 per body area	96 MFG Med GR I E 3	Rule states muscle testing is reimbursed per body area. Compensable injury is to the neck. No additional reimbursement is recommended.
9/25/01	97750-MT	\$172.00	86.00	F			
1/14/02	97750-MT	\$172.00	43.00	F			
7/18/01	99070	\$ 6.00	0.00	U	DOP	IRO Decision	The IRO determined this service to be medically necessary. Recommend reimbursement of \$ 6.00.
2/27/02	99213 97265 97250 97150 97110	\$ 50.00 \$ 43.00 \$ 43.00 \$ 27.00 \$280.00	0.00	U	\$ 48.00 \$ 43.00 \$ 43.00 \$ 27.00 \$ 35.00 ea 15min		The IRO determined that care past 9-18-01 was not medically necessary.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Max. Allowable Reimbursement)	Reference	Rationale
3/1/02	99213 97265 97250 97150 97110	\$ 50.00 \$ 43.00 \$ 43.00 \$ 27.00 \$245.00	0.00	U			Therefore, no reimbursement recommended.
3/6/02	99213 97150 97110	\$ 50.00 \$ 27.00 \$280.00	0.00	U			
3/13/02	99213 97265 97250 97150 97110	\$ 50.00 \$ 43.00 \$ 43.00 \$ 27.00 \$280.00	0.00	U			
3/18/02	99213 97265 97250 97150 97110 99070	\$ 50.00 \$ 43.00 \$ 43.00 \$ 27.00 \$280.00 \$ 8.00	0.00	U	\$ 48.00 \$ 43.00 \$ 43.00 \$ 27.00 \$ 35.00 ea 15min	IRO Decision	The IRO determined that care past 9-18-01 was not medically necessary. Therefore, no reimbursement recommended.
TOTAL	\$2442.00	\$172.00	The requestor is entitled to reimbursement of \$6.00				

On this basis, the total amount recommended for reimbursement (\$ 6.00) 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.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay \$ 6.00 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 7-13-01 through 3-18-02 in this dispute.

This Order is hereby issued this 15th day of April 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

October 21, 2002

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.

This case was reviewed by a licensed Doctor of Chiropractic. 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 treated for 44 weeks with little difference in pain improvement. Functional Capacity Evaluations did not show significant improvement to justify additional care after 8 weeks. No positive findings on MRI or other advanced diagnostic testing was presented.

DISPUTED SERVICES

Chiropractic care from July 18, 2001 to March 18, 2002.

DECISION

Care past a date of September 18, 2001 is not warranted.

BASIS FOR THE DECISION

The patient pain levels did not show significant change during the course of care. There was a lack of objective findings to warrant additional care and the diagnostic testing after an 8 week

trial of care is not necessary. It should also be noted that the doctor changed the diagnosis on November 25, 2001 after the patient was involved in a MVA. Additional care for the new diagnosis would not be related to the compensable work injury.

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,