

MDR Tracking Number: M5-02-3086-01

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 and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(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. There are unresolved fee issues.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
10/1/01 10/2/01 10/3/01 10/5/01 10/8/01 10/10/01 10/12/01 10/17/01 10/19/01 10/22/01 10/24/01 10/26/01 11/01/01 11/2/01 11/7/01 11/9/01 11/12/01 11/14/01 11/16/01 11/21/01 11/23/01 11/26/01 11/28/01 12/3/01 12/5/01	99213	50.00 x 41 = \$2,050.00	0.00	T, U	\$ 48.00	IRO Decision	IRO deemed these office visits as medically necessary. Recommend reimbursement of \$ 48.00 x 41 = \$1,968.00.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
12/7/01 12/10/01 12/14/01 12/17/01 12/19/01 1/9/02 1/18/02 1/25/02 2/1/02 2/8/02 2/15/02 2/22/02 3/1/02 3/8/02 3/13/02 4/3/02							
12/01/01	95851 x 2	\$100.00	0.00	U	\$ 36.00 ea extremity	IRO Decision	IRO deemed the range of motion testing as medially necessary. Recommend reimbursement of \$ 36.00 x 2 = \$ 72.00.
9/18/01	99071 99002	\$ 15.00 \$ 15.00	0.00	N G	DOP \$ 10.00	96 MFG Med GR; CPT descriptor	Requestor did not submit documentation to support services rendered. No reimbursement recommended.
10/9/01	95851 x 2	\$100.00	0.00	G	\$ 36.00 ea extremity	96 MFG Med GR D; CPT Descriptor	EOB states this service is an integral component of another service but does not state the other service. Range of motion (ROM) is not global unless performed by a physical therapist per MFG Medicine GR I A 8. A doctor of chiropractic conducted the ROM testing. ROM report supports testing to hip and knee area. Hip/knee is counted as one region; therefore, recommend reimbursement of \$ 36.00.
10/1/01 10/3/01	97110	\$ 70.00 \$ 70.00	0.00	A	\$35.00 ea 15 min	96 MFG Med GR I A 10 a; TWCC Rule 134.600 (h)	Table of disputed services states preauthorization was obtained under # TV081710N; however, preauthorization letter was not submitted as required. No reimbursement recommended.
10/2/01	L3030	\$300.00	\$19.95	M	DOP	96 MFG DME GR IV; §413.011(b)	Requestor submitted an invoice dated 9-26-01 for an Ultrastep for \$250.00; however, the requestor did not provide documentation per the criteria of the Texas Labor Code to support a need for a change in the reimbursement. Therefore, no additional reimbursement is recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
TOTAL		\$2,720.00	\$19.95				The requestor is entitled to reimbursement of <b>\$2,076.00.</b>

The above Findings and Decision are hereby issued this 26<sup>th</sup> day of March 2003.

Dee Z. Torres  
 Medical Dispute Resolution Officer  
 Medical Review Division

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay \$2,076.00 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 9-18-01 through 4-3-02 in this dispute.

This Order is hereby issued this 26th day of March 2003.

Roy Lewis, Supervisor  
 Medical Dispute Resolution  
 Medical Review Division

RL/dzt

November 19, 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.

The independent review was performed by a matched peer with the treating doctor. 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

\_\_\_ suffered a work-related injury on \_\_\_ when a large sign that he and a fellow employee were attempting to load onto a truck fell and crushed him to the ground, resulting in a fracture of the left femur and injuries to his left hip and knee and spine. He underwent surgical repair of the comminuted fracture to his left femur and subsequent post-surgical rehabilitation.

#### DISPUTED SERVICES

Under dispute is the medical necessity of office visits and range of motion testing for dates of service ranging from 10/1/01 through 4/3/02.

#### DECISION

The reviewer disagrees with the prior adverse determination.

#### BASIS FOR THE DECISION

Based on guidelines for Peer Review/Utilization Review Certification Guidelines by Greg Fisher, D.C., chapter 16, pages 166-167, for E/M procedures of established patients, two of the three components (history, examination, medical decision making) must be met or exceeded for a particular level of E/M service. At the level of 99213: presenting problem is low to moderate; the history is expanded; the examination is also expanded and the decision-making is low. The office visit notes for the dates of service from 10/2/01 through 4/3/02 do meet the requirements in at least two of the criteria. (Again, two of the three components must be met.)

Based on the Spine Treatment Guidelines effective 6/1/95, re-evaluations should be conducted every thirty days unless symptoms dictate otherwise. The components contained in the ranges of motion tests performed during the dates of service in question do meet those guidelines.

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,