MDR Tracking Number: M5-03-2325-01

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 05-14-03.

The IRO reviewed therapeutic exercises, electrical stimulation, myofascial release, joint mobilization, range of motion measurements, gait training and muscle testing rendered on 08-22-02, 09-06-02 and 09-19-02 through 10-07-02 that were denied based upon "U" and "V".

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 08-07-03, 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	MAR$	Reference	Rationale
7-30-02 through 8-28-02 (2 DOS)	97750-MT	$46.00 (1 unit X 2 DOS)	$0.00	No EOB	$43.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of $43.00 X 2 DOS = $86.00
8-6-02 through	95851	$38.00 (1 unit X 2	$0.00	No EOB	$36.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
8-20-02 (2 DOS)		DOS)					support delivery of service. Reimbursement recommended in amount of $36.00 X 2 DOS = $72.00
8-15-02 through 9-17-02 (4 DOS)	97032	$48.00 (2 units X 4 DOS)	$0.00	T, F	$22.00	Advisory 2002-11; Rule 133.304(C); Rule 133.307 (g)(3)(A-F)	T- Carrier denied outside of treatment guidelines. Treatment guidelines were abolished by statute effective 1-1-02. Review will be done per Rule 133.307(g)(3)(A-F). Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of $22.00 X 2 units X 4 DOS = $176.00
8-30-02 through 9-12-02 (4 DOS)	97010	$11.00 (1 unit X 4 DOS)	$0.00	No EOB	$11.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of $11.00 X 4 DOS = $44.00
10-1-02 through 10-7-02 (4 DOS)	97250	$46.00 (1 unit X 4 DOS)	$0.00	No EOB	$43.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of $43.00 X 4 DOS = $172.00
10-1-02 through 10-7-02 (4 DOS)	97265	$46.00 (1 unit X 4 DOS)	$0.00	No EOB	$43.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of $43.00 X 4 DOS = $172.00
10-1-02 through 10-7-02 (4 DOS)	99213	$51.00 (1 unit X 4 DOS)	$0.00	No EOB	$48.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
							Reimbursement recommended in amount of $48.00 X 4 DOS = $192.00
10-11-02 through 10-16-02 (2 DOS)	97545-WH	$102.40 (1 unit X 2 DOS)	$0.00	No EOB	$64.00 per hour	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of $64.00 X 2 DOS = $128.00
10-11-02 through 10-16-02 (2 DOS)	97546-WH	$307.20 (6 units X 2 DOS)	$0.00	No EOB	$64.00 per hour	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of $307.20 X 2 DOS = $614.40
12-12-02	97750-FC	$315.00 (3 units)	$0.00	No EOB	$100.00 per hour	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of $100.00 X 3 units = $300.00
TOTAL		$2,014.20	$0.00		$2,022.00		The requestor is entitled to reimbursement in the amount of $1,956.40

This Decision is hereby issued this 22nd day of March 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

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 07-30-02 through 12-12-02 in this dispute.

This Order is hereby issued this 22nd day of March 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dlh

July 24, 2003

IRO Certificate# 5259
MDR Tracking Number: M5-03-2325-01

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
On fell 15 ft. while at work and fractured his proximal right tibia with extensive comminution involving the lateral tibial plateau. Moderate hemiarthrosis was noted as well as fracture of the fibular head. He underwent open reduction internal fixation of the tibial fracture.

REQUESTED SERVICE (S)
Therapeutic exercises, electrical stimulation, myofascial release, joint mobilization, range of motion measurements, gait training and muscle testing; dates 8/22/02, 9/6/02, 9/19/02 through 10/7/02.

DECISION
These procedures are warranted on these dates.

RATIONALE/BASIS FOR DECISION

___stated passive range of motion should be started on 7/17/02 with ___ and patient should not begin any form of weight bearing exercises until he is released to do so. On 8/23/02 a peer review was requested where ___ states it would be appropriate for the patient to receive treatment 3 times per week for 4 weeks and 2 times per week the following 4 weeks. On 12/16/02 the patient was evaluated at ___ by ___ and found no to be at MMI and prescribed 5 more weeks of work hardening. On 12/23/02 ___ recommends to continue with treatments with ___. Upon review of the patient progress, daily notes, treatment plan, and recommendations from treating and reviewing doctors, these treatments and dates of treatments are with standards of care.