

MDR Tracking Number: M5-04-0019-01

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 08-29-03. Dates of service 08-01-02 through 08-28-02 per Rule 133.308(e)(1) were not timely filed, therefore will not be considered in this review.

The IRO reviewed office visits with manipulations, therapeutic exercises, electric stimulation, ultrasound therapy, manual traction, myofascial release and aquatic therapy rendered from 08-29-02 through 12-30-02 that was 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 12-19-03, 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	MARS	Reference	Rationale
9-4-02	99213-MP	\$68.00 (1 unit)	\$0.00	F	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
9-4-02	97035	\$31.00 (1 unit)	\$0.00	F	\$22.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
9-4-02	97122	\$49.00 (1 unit)	\$0.00	F	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to

							support delivery of service. No reimbursement recommended.
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DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
9-4-02	97250	\$61.00 (1 unit)	\$0.00	F	\$43.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended
TOTAL		\$209.00	\$0.00				The requestor is not entitled to any reimbursement.

This Decision is hereby issued this 5th day April 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 8-29-02 through 12-30-02 in this dispute.

This Order is hereby issued this 5th day of April 2004.

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

December 17, 2003

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

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___ 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 injured on ___. She began seeing ___ in June 2002. She reported hand/wrist pain, knee pain and low back pain. She was sent for MRI's which revealed specific injuries. She was treated with manipulation, therapeutic exercise, electric stimulation, ultrasound, traction, myofascial release, aquatic therapy from 8/29/02 through 12/30/02. Carrier has denied these treatments as not medically necessary.

DISPUTED SERVICES

Under dispute is the medical necessity of office visits with manipulation, therapeutic exercises, electric stimulation, ultrasound, traction, myofascial release and aquatic therapy.

DECISION

The reviewer both agrees and disagrees with the prior adverse determination.

The reviewer finds that all office visits with manipulations, therapeutic exercise, traction, myofascial release, and aquatic therapy were medically necessary and appropriate.

However, all passive modalities, code 97014 & 97035 were not medically necessary.

BASIS FOR THE DECISION

This patient was injured on the job and sought care at ___ under the care of ___. Various diagnostic testing procedures were performed which revealed the extent of this patient's injuries. Appropriate referrals were made to other health care provider specialists, who recommended further conservative care in conjunction with the care they were rendering. Since ___ was the gatekeeper on this case, it was his responsibility to continually evaluate and coordinate care of this patient. The reviewer finds that the office visits with manipulation, therapeutic exercises, traction, myofascial release & aquatic therapy were medically necessary.

Since the charges in dispute are after the initial six week time frame for passive modalities, passive modalities 97035 & 97014 were not medically unnecessary. Adequate documentation does exist to substantiate treatment for injuries sustained in this work-related accident in the time frame in question.

___ 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,