

MDR Tracking Number: M5-04-0587-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 10-24-03.

The IRO reviewed office visits, joint mobilization, electric stimulation, traction, hot/cold packs, therapeutic exercises, neuromuscular stimulator (electronic shock unit), myofascial release, vasopneumatic device, aquatic therapy, and unlisted therapeutic procedure from 11-14-02 through 7-17-03.

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.

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

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 1-6-04, 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 (Max. Allowable Reimbursement)	Reference	Rationale
11/8/02	99205 97265 97032 97012 97010	\$105.00 \$45.00 \$20.00 \$20.00 \$16.00	\$0.00 \$43.00 \$20.00 \$20.00 \$11.00	N F F F F	\$105.00 \$43.00 \$22.00 \$20.00 \$11.00	96 MFG E/M GR IV C 2 and Rule 133.307(g)(3) (A-F)	99205. Three key components are required – comprehensive history, comprehensive exam, and medical decision making of high complexity. Examination Form dated 11-8-02 does not support all three requirements; therefore, no reimbursement recommended. Codes 97265, 97032, 97012, 97010 were paid per carrier's check #08726032 on 1-7-03; therefore, no

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Max. Allowable Reimbursement)	Reference	Rationale
							dispute exists.
11/18/02	99213 97265 97032 97012 97010	\$50.00 \$45.00 \$20.00 \$20.00 \$16.00	\$0.00	No EOB	\$48.00 \$43.00 \$22.00 \$20.00 \$11.00	Rule 133.307(g)(3)) (A-F)	Daily note supports delivery of services. Recommend reimbursement of \$48.00 + \$43.00 + \$20.00 + \$20.00 + \$11.00 = \$142.00.
1/14/03 6/4/03 6/30/03	99080-73 x 3	\$15.00 x 3	\$0.00	F F, O F	\$15.00	Rule 129.5	Work status report supports delivery of service on 1/14/03 and 6/4/03. Recommend reimbursement of \$30.00.
1/20/03	99361	\$55.00	\$0.00	F	\$53.00	E/M GR V and 133.307(g)(3)) (A-F)	Carrier denied as "F - ...coordination of care is inclusive in the normal scope of practice of the treating doctor." Daily note of 1-20-03 indicates a patient encounter; therefore, per rule, no reimbursement recommended.
4/2/03	99212 95851 x2 97750- MT x2 93799 95834	\$35.00 \$80.00 \$200.00 \$122.00 \$120.00	\$0.00	U G G G G	\$32.00 \$36.00 ea extrem \$43.00 ea body area DOP \$116.00	IRO Decision Med GR I E 2 and Rule 133.307(g)(3)) (A-F)	IRO stated that the office visit was not medically necessary. Office visit, ROM, muscle testing, and functional abilities testing are global to an FCE. Report indicates requestor billed components of an FCE. Start and end time was documented at 1.5 hours. Recommend reimbursement of \$150.00.
6/4/03	99213	\$50.00	\$48.00	F	\$48.00	133.307(g)(3)) (A-F)	Carrier submitted copy of check # 08934315 to support payment; therefore, no dispute exists.
TOTAL		\$1,064.00	\$0.00				The requestor is entitled to reimbursement of \$322.00.

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 Order is applicable for dates of service 11-18-02 through 6-4-03 in this dispute.

This Order is hereby issued this 27th day of February 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION amended

December 31, 2003

Re: IRO Case # M5-04-0587

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient injured her neck, right shoulder and lower back in ___ when a large person whom she was taking for a walk had a seizure and fell on top of her. The patient was evaluated with electrodiagnostic studies, MRIs, and CT myelogram. She was treated with medication, physical therapy and chiropractic treatment.

Requested Service(s)

Office visit, joint mobilization, electric stim, traction therapy, hot/cold pack, therapeutic exercises, neuromus stimulator, electronic shock unit, myo release, vasopneumonic device therapy, aquatic therapy, OV/ est patient, unlisted therapeutic procedure 11/14/02-7/17/03

Decision

I agree with the carrier's decision to deny the requested treatment.

Rational

The patient received extensive chiropractic treatment without documented relief of symptoms or improved function. A report dated 9/3/03 noted that the patient continued, "to have neck pain and radicular pain down the right arm involving all the fingers." The report further noted, "she has had no significant improvement with TENS unit, physical therapy or chiropractic treatment." In addition, the report said that the patient had had multiple positive orthopedic tests, 50% loss of all cervical spine ranges of motion, decreased sensation in the right C6 distribution, and painful right shoulder range of motion in abduction and internal rotation. This was after some eight months of extensive conservative treatment, indicating that treatment was not beneficial.

The doctor's treatment notes provided for review are limited vague and often illegible. Objective, quantifiable findings are limited. Monthly reports from a treating D.O. also show a lack of response to the chiropractic treatment

The documentation fails to support the use of therapeutic exercises or aquatic therapy, as it lacks description of specific exercises used and the patient's response to the exercises. The documentation also lack a specific plan of treatment. Every visit consists of different passive or active modalities without a reason for changing the treatment protocol. The patient's ongoing and chronic care did not appear from the records provided to be producing measurable or objective improvement.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.