

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-04-4289.M5**

MDR Tracking Number: M5-04-0604-01

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 8-25-03.

The IRO reviewed supplies and materials, therapeutic exercises, therapeutic procedures, office visit, myofascial release, and joint mobilization from 8-27-02 through 10-30-02.

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.

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

On 12-31-03, 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\$ (Max. Allowable Reimbursement)	Reference	Rationale
8-27-02	99070 (OTC muscle relaxer)	\$6.00	\$0.00	F, RI	DOP	96 MFG General Instruction IV and Rule 133.307(g)(3)	Carrier denied as "F, RI - take home meds are only reimbursable when provided by a retail pharmacy and billed on a TWCC-66 pharmacy form." Per rule, supplies and materials provided during an office visit in excess of \$5.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
							may be billed with code 99070. Patient Office Visit Report dated 8-27-02 supports delivery of service. Recommend reimbursement of \$6.00.
9-10-02	97024	\$25.00	\$0.00	F,85	\$21.00	96 MFG Med GR I A 10 a; Rule 133.307(g)(3)	Carrier denied as "F, 85 - Procedure exceeds maximum fee schedule pay for value and/or time on a single date of service." The charge for physical medicine treatment shall not exceed any combination of four modalities as referenced in the rule. The HCFA supports five modalities; therefore, no reimbursement can be recommended.
9-17-02	99215 95851(2) 97750-MT(5)	\$125.00 \$80.00 \$215.00	\$0.00	N,F,TG G, 19 G, 19	\$103.00 \$36.00 \$43.00 per body area	96 MFG E/M GR IV C 2 and VI B Med GR I E 3 & 4	Subsequent Medical Narrative Report dated 9-17-02 supports level of service, ROM and muscle testing for two body areas. ROM testing and

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
							muscle testing is not global to an office visit. Recommend reimbursement of \$103.00 + \$72.00 + \$86.00 = \$261.00.
10-2-02 10-4-02 10-9-02 10/11/02 10/21/02 10/25/02	97150	\$27.00 \$27.00 \$27.00 \$27.00 \$27.00 \$27.00	\$0.00	F, 85	\$27.00	Med GR I A 10 a and Rule 133.307(g)(3)	Carrier denied as "F, 85 - Procedure exceeds maximum fee schedule pay for value and/or time on a single date of service." The charge for physical medicine treatment shall not exceed any combination of four modalities as referenced in the rule. The HCFA supports four modalities. Patient Office Visit Reports support delivery of service and did not exceed four modalities. Recommend reimbursement of \$27.00 x 6 = \$162.00
10/23/02	97750-MT	\$129.00(3)	\$43.00	F, 05	\$43.00 per body area	Med GR I E 3 and Rule 133.307(g)(3)	Carrier denied as "F, 05 - value of the procedure is included in the value of another procedure performed on this date." Muscle testing is not global to an office visit. Muscle testing report

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
							dated 10-23-02 does not support delivery of service to more than one area. No additional reimbursement can be recommended.
11/7/02	95851 97750-MT	\$80.00(2) \$215.00(5)	\$0.00 \$43.00	G, 19	\$36.00	Med GR I E 3 & 4 and Rule 133.307(g)(3)	ROM and muscle testing is not global to an office visit. Subsequent Medical Narrative dated 11-7-02 supports delivery of service to two body areas. Recommend reimbursement of \$72.00 + \$43.00 = \$115.00.
1-21-03	99455-L5-WP 99070	\$450.00 \$6.00	\$0.00	O,F,N	\$300.00 one body area and \$150.00 ea adjl. body area	E/M XXII and Rule 133.307(g)(3)	Medical Narrative Report dated 1-21-03 supports delivery of service. Recommend reimbursement of \$450.00. Patient Office Visit Report dated 1-23-03 supports delivery of service for OTC muscle relaxer. Recommend reimbursement of \$6.00.
1-24-03	99213	\$50.00	\$0.00	F, N	\$48.00	96 MFG E/M GR IV C 2; VI B and Rule 133.307(g)(3)	Patient Office Visit Report dated 1-24-03 does not support documentation requirements in that notes only

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
							included an expanded problem focused history. No reimbursement can be recommended.
3-28-03	99213 97024 97250 97265	\$50.00 \$25.00 \$43.00 \$43.00	\$0.00	D	\$48.00 \$21.00 \$43.00 \$43.00	96 MFG E/M GR IV C 2; VI B; Med GR I A 10 a; and Rule 133.307(g)(3)	Orig EOBs were not submitted. Patient Office Visit Report dated 3-28-03 supports delivery of services. Recommend reimbursement of \$48.00 + \$21.00 + \$43.00 + \$43.00 = \$155.00.
TOTAL		\$1,704.00	\$86.00				The requestor is entitled to reimbursement of \$705.00.

This Decision is hereby issued this 9th day of February 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

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 8-27-02 through 3-28-03 in this dispute.

This Order is hereby issued this 9th day of February 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Amended Letter

Note: Injured Worker

December 23, 2003

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: MDR Tracking #: M5-04-0604-01
IRO Certificate #: IRO 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional has signed a certification statement stating 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 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 this case.

Clinical History

This patient sustained a repetitive injury on ___ while pushing boxes onto a pallet all day. A left shoulder MRI dated 09/01/02 revealed a partial tear of the anterior supraspinatus tendon and presence on fluid. He saw a chiropractor for treatment and therapy.

Requested Service(s)

Supplies and materials, therapeutic exercises, therapeutic procedures, office visit, myofascial release, and joint mobilization from 08/27/02 through 10/30/02

Decision

It is determined that the supplies and materials, therapeutic exercises, therapeutic procedures, office visit, myofascial release, and joint mobilization from 08/27/02 through 10/30/02 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient was initially evaluated by his chiropractor on 08/27/02. Subjective symptoms and positive examination findings led to an initial trial of chiropractic care with passive and active therapy. As his MRI dated 09/01/02 showed significant injuries, extended care was indicated.

The records clearly provided sufficient documentation to warrant the care rendered. The SOAP notes, range of motion (ROM) testing, and muscle testing results revealed documented evidence of improvement that further validates the treatment this patient received. Therefore, it is determined that the supplies and materials, therapeutic exercises, therapeutic procedures, office visit, myofascial release, and joint mobilization from 08/27/02 through 10/30/02 were medically necessary.

Sincerely,