

MDR Tracking Number: M5-04-1124-01

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 12-18-03.

The IRO reviewed joint mobilization, therapeutic exercises, office visits, manual traction therapy, neuromuscular re-education and various special services rendered from 06-04-03 through 10-17-03 that were denied based upon "U".

The IRO determined that treatment and services during the period of 06-04-03 through 07-09-03 (with the exception of joint mobilization) **were** medically necessary. The office visits and therapeutic exercises during 07-12-03 through 10-17-03 **were** medically necessary. All other treatment and services in dispute during 07-12-03 through 10-17-03 **were not** medically necessary.

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 03-01-04, 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.

CPT code 99205 date of service 05-09-03 denied with denial code "F" (fee guideline reduction). Per the 96 Medical Fee Guideline EVALUATION AND MANAGEMENT GR VI(A) reimbursement is recommended in the amount of \$137.00.

CPT code 72052-WP date of service 05-09-03 denied with denial code "F" (fee guideline reduction). Per the 96 Medical Fee Guideline RADIOLOGY/NUCLEAR MEDICINE GR I (A)(2) reimbursement is recommended in the amount of \$132.00.

CPT code 72110-WP date of service 05-09-03 denied with denial code "F" (fee guideline reduction). Per the 96 Medical Fee Guideline RADIOLOGY/NUCLEAR MEDICINE GR I (A)(2) reimbursement is recommended in the amount of \$100.00

CPT code 99080-73 dates of service 05-23-03, 06-06-03, 06-19-03 and 07-08-03 denied with denial code "F" (fee guideline reduction). Per Rule 133.307 (g)(3)(A-F) reimbursement is recommended in the amount of \$60.00 (\$15.00 X 4 DOS).

CPT code 97265 dates of service 05-30-03 through 07-07-03 (9 DOS) denied with denial code "F" (fee guideline reduction). Per the 96 Medical Fee Guideline MEDICINE GR I (9)(c) reimbursement is recommended in the amount of \$387.00 (\$43.00 X 9 DOS).

CPT code 99354 dates of service 06-04-03, 06-16-03, 06-18-03, 06-30-03 and 07-02-03 (5 DOS) denied with denial code "N" (not appropriately documented). The requestor submitted information to support documentation criteria. Reimbursement is recommended in the amount of \$530.00 (\$106.00 X 5 DOS).

CPT code 99090 dates of service 06-09-03 through 07-12-03 (7 DOS) denied with denial code "N" (not appropriately documented). The requestor submitted information to support documentation criteria. Reimbursement is recommended in the amount of \$756.00 (\$108.00 X 7 DOS).

Review of CPT code 97265 date of service 06-12-03 and 07-16-03 revealed neither the requestor nor the respondent submitted copies of EOB's. Per Rule 133.308(f)(2)(3) the requestor did not submit proof of convincing evidence of carrier receipt of the resubmission reconsideration request. No reimbursement is recommended.

CPT code 99214 date of service 07-08-03 denied with denial code "N" (not appropriately documented). The requestor submitted information to support documentation criteria. Reimbursement is recommended in the amount of \$71.00.

Review of CPT code 97260 date of service 07-16-03 revealed neither the requestor nor the respondent submitted a copy of an EOB. Per Rule 133.308(f)(2)(3) the requestor did not submit proof of convincing evidence of carrier receipt of the resubmission reconsideration request. No reimbursement is recommended.

Review of CPT code 97122 date of service 07-16-03 revealed neither the requestor nor the respondent submitted a copy of an EOB. Per Rule 133.308(f)(2)(3) the requestor did not submit proof of convincing evidence of carrier receipt of the resubmission reconsideration request. No reimbursement is recommended.

Review of CPT code 97112 date of service 07-16-03 revealed neither the requestor nor the respondent submitted a copy of an EOB. Per Rule 133.308(f)(2)(3) the requestor did not submit proof of convincing evidence of carrier receipt of the resubmission reconsideration request. No reimbursement is recommended.

Review of CPT code 64999-22 date of service 07-16-03 revealed neither the requestor nor the respondent submitted a copy of an EOB. Per Rule 133.308(f)(2)(3) the requestor did not submit proof of convincing evidence of carrier receipt of the resubmission reconsideration request. No reimbursement is recommended.

Review of CPT code 97014 date of service 07-16-03 revealed neither the requestor nor the respondent submitted a copy of an EOB. Per Rule 133.308(f)(2)(3) the requestor did not submit proof of convincing evidence of carrier receipt of the resubmission reconsideration request. No reimbursement is recommended.

Review of CPT code 99080-73 date of service 07-18-03 revealed neither the requestor nor the respondent submitted a copy of an EOB. Per Rule 133.308(f)(2)(3) the requestor did not submit proof of convincing evidence of carrier receipt of the resubmission reconsideration request. No reimbursement is recommended.

CPT code 99080 date of service 09-15-03 denied with denial code "G" (global). The carrier did not specify which denial code 99080 was global to. Reimbursement is recommended in the amount of \$99.75.

Review of CPT code 99090 date of service 10-02-03 revealed neither the requestor nor the respondent submitted a copy of an EOB. Per Rule 133.308(f)(2)(3) the requestor did not submit proof of convincing evidence of carrier receipt of the resubmission reconsideration request. No reimbursement is recommended.

This Findings and Decision is hereby issued this 2nd day of November 2004.

Debra L. Hewitt
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) and in accordance with Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c) 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 06-04-03 through 09-15-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 2nd day of November 2004.

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

February 26, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-1124-01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

REVIEWER'S REPORT

Information Provided for Review:

Correspondence and Plan documentation
H&P and office notes
Physical Therapy notes
Functional Capacity Evaluation
Operative report
Radiology report

Clinical History:

The records indicate he was injured on the job on ___, resulting in multiple injured areas. He sought medical care for his injuries, and a treatment program was begun. The patient received some treatment and medication after his injury. However, he had inconsistent improvement of his symptoms, so he sought care in another office. An initial evaluation was performed on 5/9/03, and an aggressive treatment program of chiropractic care and passive care 6 times a week for 1 week and 3 times a week for 5 weeks with a progression into rehabilitative measures was begun.

Disputed Services:

Joint mobilization, therapeutic exercises, office visits, manual traction therapy, neuromuscular re-education, and various special services during the period of 06/04/03 through 10/17/03.

Decision:

The reviewer partially agreed with the determination of the insurance carrier and is of the opinion that all treatment and services in dispute as stated above rendered during the period of 06/04/03 through 07/09/03, with the exception of joint mobilization (97265), were medically necessary. The office visits (99213) and therapeutic exercises (97110) during the period of 07/12/03 through 10/17/03 were medically necessary. All other treatment and services in dispute as stated above rendered during the period of 07/12/03 through 10/17/03 were not medically necessary in this case.

Rationale:

National Treatment Guidelines allow for this type of treatment for these types of injuries. Normally, 2-4 weeks of passive therapy is allowed; however, due to multiple injured areas, up to 8 weeks of passive therapy would be appropriate in conjunction with progression into an active therapy program. Joint mobilization, code #97265 and manipulation/spinal adjustments have the same or similar therapeutic effects. The records do not provide sufficient documentation to clinically justify joint mobilization.

Sincerely,