

MDR Tracking Number: M5-04-1382-01

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 January 16, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. The office visits; therapeutic exercises, therapeutic activities and work hardening from 08-04-03 through 11-17-03 **were found** to be medically necessary. 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 March 23, 2004, 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
08-13-03	99213	\$66.19	\$0.00	No EOB	\$66.19	Medicare Fee Schedule	Review of the requestors and respondent's documentation revealed that neither party submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of \$66.19.
08-19-03	99213	\$66.19	\$0.00	No EOB	\$66.19	Medicare Fee Schedule	Review of the requestors and respondent's documentation revealed that neither party submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of \$66.19.
09-24-03	97545 WH-CA	\$128.00	\$64.00	F	\$64.00 x 2hrs	Medicare Fee Schedule Rule 134.202(c)(5)(C)	The requestor submitted relevant documentation to support services rendered. Recommend additional reimbursement of \$64.00.
09-25-03	97546 WH-CA	\$320.00	\$256.00	F	\$64.00 x 5hrs	Medicare Fee Schedule Rule 134.202(c)(5)(C)	The requestor submitted relevant documentation to support services rendered. Recommend additional reimbursement of \$64.00.
09-30-03	97546 WH-CA	\$384.00	\$307.20	F	\$64.00 x 6hrs	Medicare Fee Schedule Rule 134.202(c)(5)(C)	The requestor submitted relevant documentation to support services rendered. Recommend additional reimbursement of \$76.80.
10-17-03	97750-FC	\$295.52	\$0.00	No EOB	\$36.94 (each 15min) x 2hrs	Medicare Fee Schedule	Review of the requestors and respondent's

							documentation revealed that neither party submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of \$295.52.
10-31-03	97545 WH-CA 97546 WH-CA	\$128.00 \$384.00	\$0.00 \$0.00	No EOB	\$64.00 x 2hrs \$64.00 x 6hrs	Medicare Fee Schedule Rule 134.202(c)(5)(C)	Review of the requestors and respondent's documentation revealed that neither party submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of \$512.00.
11-17-03	97750-FC	\$443.28	\$0.00	No EOB	\$36.94 (each 15min) x 3hrs	Medicare Fee Schedule	Review of the requestors and respondent's documentation revealed that neither party submitted EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of 443.28.
TOTAL		\$2215.18	\$627.20				The requestor is entitled to 1587.98.

This Findings and Decision is hereby issued this 8th day of October 2004.

Patricia Rodriguez
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 for dates of service after August 1, 2003 per Commission Rule 134.202 (b); 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 08-04-03 through 11-17-03 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 8th day of October 2004.

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

March 17, 2004

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

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IRO #: 5251

___ 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

The documentation presented states ___ was working in a slaughterhouse cleaning rollers and hooks when some of the hooks fell on his face, breaking his nose and injuring his neck. The patient sought care at ___ with Dr. P. The patient had an MRI of the cervical spine that revealed cervical spondylosis and the patient was referred for an MRI of the brain that revealed a negative study. The patient was also referred for a series of cervical epidural steroid injections that he did undergo. The carrier has denied office visits, exercises, activities and work hardening due to unnecessary medical treatment from the dates 8/4/03 thru 11/17/03.

DISPUTED SERVICES

Under dispute is the medical necessity of office visits, exercises, activities and work hardening.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ reviewer finds medical necessity for the treatment provided for the dates of service in question. The treatment provided displayed subjective and objective functional gain from the SOAP notes and FCEs provided for review. There was nothing in the record from the carrier stating otherwise. The patient appears to have needed a multidisciplinary approach due to the functional deficits displayed on the FCE results and underlying psychosocial issues.

The determination falls within the Mercy Fee Guidelines, Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters, and well within the mainstream of the medical community.

___ 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,