

MDR Tracking Number: M5-04-1612-01

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 11-03-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that office visits, joint mobilization, therapeutic exercises, neuromuscular re-education, and myofascial exercises rendered from 5/19/03 through 8/11/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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 February 26, 2003, 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 99211 for date of service 5/27/03 was denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's within the 14 day time frame in accordance with Rule 133.307(e)(2) and (3). Review of the reconsideration HCFA and facsimile confirmation reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed service will be reviewed according to the 1996 MFG. **Reimbursement is recommended in the amount of \$18.**

CPT code 97250 for date of service 5/27/03 was denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's within the 14 day time frame in accordance with Rule 133.307(e)(2) and (3). Review of the reconsideration HCFA and facsimile confirmation reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed service will be reviewed according to the 1996 MFG. **Reimbursement is recommended in the amount of \$43.**

CPT code 99214 for date of service 8/12/03 was denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's within the 14 day time frame in accordance with Rule 133.307(e)(2) and (3). Review of the reconsideration HCFA and facsimile confirmation reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed service will be reviewed according to the fee guidelines. **Reimbursement is recommended in the amount of \$71.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- in accordance with Medicare program reimbursement methodologies for dates of service after 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 Order is applicable to dates of service 5/27/03 and 8/12/03 as outlined above 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 Decision and Order is hereby issued this 1st day of November 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

January 28, 2004

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

RE: Injured Worker:
MDR Tracking #: M5-04-0671-01
New MDR Tracking #: M5-04-1612-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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. TMF's 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 TMF 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 an injury on ____, mechanism unknown. There was no clinical documentation provided for review.

Requested Service(s)

Office visits, joint mobilization, therapeutic activities, neuromuscular re-education of movement, myofascial exercises, office visit-may not require a physician, office visit-established patient from 05/19/03 through 08/11/03

Decision

It is determined that the office visits, joint mobilization, therapeutic activities, neuromuscular re-education of movement, myofascial exercises, office visit-may not require a physician, office visit-established patient from 05/19/03 through 08/11/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The documentation presented for review does not support the necessity of services applied by the provider from 05/19/03 through 08/11/03. Non-approval of treatment is appropriate given the lack of qualitative and quantitative documentation to warrant the trial of therapeutics rendered. Therefore, it is determined that the office visits, joint mobilization, therapeutic activities, neuromuscular re-education of movement, myofascial exercises, office visit-may not require a physician, office visit-established patient from 05/19/03 through 08/11/03 were not medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- *Overview of implementation of outcome assessment case management in the clinical practice.* Washington State Chiropractic Association; 2001. 54p.
- Yeomans DC, SG. *Applying Outcomes Management into Clinical Practice.* J Neuromusculoskel System Summer 1997; 5(2):1-14.

Sincerely,

A handwritten signature in black ink, appearing to read "Gordon B. Strom, Jr.", written in a cursive style.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn