

MDR Tracking Number: M5-04-1777-01

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 2-17-04.

The IRO reviewed aquatic therapy, manual traction, office visits, joint mobilization, whirlpool, physician/team conference, analysis of computer stored data, electrical stimulation, muscle stimulator rental, electrodes on 2-18-03 to 7-10-03.

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 4-20-04, 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. Rationale: Neither party submitted an EOB; therefore these dates of service will be reviewed per the 1996 Medical Fee Guideline. Since the carrier did not provide a valid basis for the denial of these services, recommend reimbursement.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Recommended Allowance
2-18-03	95900-27 (4) 95904-27 (4) 95935-27 (4) 95925-27 (2)	\$256.00 \$256.00 \$212.00 \$106.00	\$0.00	No EOB	\$64.00 ea nerve x 70% = \$44.80 \$64.00 ea nerve x 70% = \$44.80 \$53.00 per study x 70% = \$37.10 \$175.00 one or more nerves x 70% = \$122.50	\$44.80 x 4 nerves = \$179.20 \$44.80 x 4 nerves = \$179.20 \$37.10 x 4 studies = \$148.40 \$106.00 for one or more nerves
2-19-03 2-21-03 2-22-03 2-24-03 2-26-03 2-28-03 4-29-03 5-2-03 6-16-03	99213-25 x 9 97265 x 9 97122 x 9	\$48.00 x 9 \$43.00 x 9 \$35.00 x 9	\$0.00	No EOB	\$48.00 \$43.00 \$35.00	\$48.00 x 9 days = \$432.00 \$43.00 x 9 days = \$387.00 \$35.00 x 9 days = \$315.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Recommended Allowance
2-19-03 2-21-03 2-24-03 2-26-03 2-28-03 4-29-03 5-2-03	97113 (5 units) 97113 (6 units) 97113 (7 units) 97113 (6 units) 97113 (6 units) 97113 (5 units) 97113 (6 units)	\$260.00 \$312.00 \$364.00 \$312.00 \$312.00 \$260.00 \$312.00	\$0.00	No EOB	\$52.00 ea 15 min	2-19-03 & 4-29-03: \$260.00 x 2 = \$520.00. 2-21-03, 2-26-03, & 2-28-03: \$312.00 x 3 = \$936.00 2-24-03: \$364.00
2-22-03 7-3-03 6-6-03	99078 E0745NU A4458 A4556	\$475.00 \$485.00 \$60.00 \$30.00	\$0.00	No EOB	DOP DOP DOP	Per Section 413.011(d) and Rule 133.307(j)(1)(F), if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the payment being sought is a fair and reasonable rate of reimbursement. The requestor did not submit relevant information to support that the billed amounts were fair and reasonable. Therefore, no reimbursement recommended.
4-17-03	99213-25 97113 (5 units)	\$48.00 \$260.00	\$0.00	No EOB	\$48.00 \$52.00 ea 15 min	\$48.00 \$52.00 x 5 = \$260.00
4-28-03 6-30-03	99362	\$95.00 x 2 days	\$0.00	No EOB	\$95.00	\$95.00 x 2 days = \$190.00.
6-6-03	95860 99241	\$113.00 \$70.00	\$0.00	No EOB	\$113.00 \$63.00	\$113.00 \$63.00
TOTAL				The requestor is entitled to reimbursement of \$4,134.80.		

The above Findings and Decision is hereby issued this 22nd day of October 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

ORDER

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 for the unpaid medical fees outlined above as follows:

- 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 2-18-03 to 6-30-03 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 22nd day of October 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-04-1777-01
IRO Certificate Number: 5259

April 5, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Sincerely,

CLINICAL HISTORY

Patient is a 41-year-old male who was injured on ___ while working for ___. No specific description of injury was provided. This patient was originally under the care and supervision of Dr. P, but no records were available for review for that care. The patient then began care with a doctor of chiropractic and the records included a copy of the referral from Dr. P.

REQUESTED SERVICE(S)

Aquatic therapy with therapeutic exercises (97113), whirlpool (97022), manual traction (97122), joint mobilization (97265), office visit, extended problem focused (99213), office visit, comprehensive (99215), physician/team conference, 60 minutes (99362), analysis of information data stored in computers (99090), electrical stimulation, attended (97032), muscle stimulator, rental (E0745-RR), and electrodes (A4556) for dates of service 02/18/03 through 07/10/03.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Although the records contained a copy of the referral from the original treating doctor to the doctor of chiropractic to “evaluate and treat,” no other records were available for review during that nearly two-year timeframe. Therefore, it is unknown what kinds of therapies and/or treatments were attempted, what was beneficial and what was not. Absent this information, the medical necessity of the services – from joint mobilization to the office visits, from the manual traction and the electrical stimulation to the whirlpool and aquatic therapeutic exercises – is not supported.

Many specific questions were not answered including: Were these treatments new or more of the same? Had manipulation/mobilization or physical therapy modalities/procedures already been performed? Had this patient already undergone a physical rehabilitation program? Was an MRI ever performed? If so, what did it reveal?

It was also not medically necessary to perform an “analysis of information stored in computers” (99090) to merely review the operative report of the epidural injection because the doctor could have simply printed the results out and read the records that were generated (the same as this reviewer has done with the copies of the “computer analysis”).

In terms of the office visits, expanded problem-focused (99213) were concerned, they were also denied because it was not medically necessary to perform this level of evaluation and management of the patient on a routine, or per visit, basis.

Finally, the records submitted provided no information whatsoever regarding the work status of this patient throughout his care. It is important to note that review of the examinations indicated that the patient’s straight leg raise actually worsened with care. On the initial date of service (01/27/03), it went from 65 degrees on the left and 60 degrees on the right to 35 degrees on the left and 50 degrees on the right according to the only follow-up examination included in the record (03/11/03).