

MDR Tracking Number: M5-04-1982-01

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 March 4, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. 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. The office visit (99213) on 04-09-03 was found to be medically necessary. The office visits (99213) on 03-05-03, 03-07-03, 03-10-03, 03-12-03, 03-14-03, 03-28-03, 04-11-03 and 04-14-03 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 06-11-04, 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:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Max. Allowable Reimbursement)	Reference	Rationale
03-24-03	99213	\$60.00	\$0.00	N	\$48.00	1996 MFG	The requestor submitted relevant information that supports documentation criteria and delivery of service for 99213. Recommend reimbursement of \$48.00.
04-16-03	99213 99080-73	\$60.00 \$20.00	\$0.00 \$0.00	D D	\$48.00 \$15.00	1996 MFG	The requestor submitted relevant information that supports delivery of services rendered therefore, these disputed services will be reviewed according to the 1996 MFG. Recommend reimbursement of \$63.00.
TOTAL		\$140.00					The requestor is entitled to reimbursement of \$ 111.00.

**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 Order is applicable for dates of service 04-09-03 and 04-16-03 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 15<sup>th</sup> day of October 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

May 19, 2004

**AMENDED LETTER**

Rosalinda Lopez  
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 #: M5-04-1982-01  
IRO Certificate #: IRO4326

The \_\_\_ 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 Medicine. \_\_\_'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 \_\_\_ 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 is a 32-year-old male firefighter/paramedic for the \_\_\_\_\_. He sustained a work-related injury on \_\_\_\_\_, while climbing down from his vehicle. He came down hard onto his left foot, twisted his ankle, and collapsed. He was treated initially at the emergency department and then presented 3 days later to a doctor of chiropractic where he received physical therapy. He was determined to be at maximum medical improvement on 06/18/03 with 2% whole-person impairment by the treating doctor.

### Requested Service(s)

Office visits billed from 03/05/03 through 04/14/03

### Decision

It is determined that the office visit billed as 99213 on 04/09/03 was medically necessary to treat this patient's condition. The remainder of the office visits billed between 03/05/03 and 04/09/03 and between 04/10/03 and 04/14/03 were not medically necessary.

### Rationale/Basis for Decision

According to the TWCC medical Fee Guidelines, (Medicine Ground Rules, I. Physical Medicine 11. B.), when a doctor of chiropractic performs manipulation, it is to be reported using an extended problem-focused Evaluation and Management (E/M) code (99213) and appended with the modifier "-MP." In the absence of manipulation, however, utilization of this code is reserved for reevaluations. The medical record documentation indicates that in this case, the performance of manipulation was not documented. Rather, the indicated space for this service on this doctor's "Daily Treatment Log" form is left blank on every encounter. Therefore, since office visits reflecting this high level of service were not medically necessary on every patient encounter, and because manipulation was not documented as having been performed, these services cannot be supported. However, the one office visit at approximately 4 weeks into care was necessary for reevaluation purposes.

Sincerely,