

MDR Tracking Number: M5-04-2414-01

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 04-02-04.

The IRO reviewed office visits, impairment rating disability exam, myofascial release, ultrasound, electrical stimulation unattended, hot/cold pack therapy, electrodes per pair, paraffin bath, paraffin per pound, manual therapy technique and chiropractic manual treatment-spinal rendered from 04-02-03 through 08-13-03 that were denied based upon "V".

The IRO determined that the office visit on date of service 04-02-03, impairment rating disability exam on 04-02-03 and chiropractic manipulative therapy on 08-08-03 **were** necessary. The IRO determined that office visits (with the exception of 04-02-03), myofascial release, ultrasound, electrical stimulation unattended, hot/cold pack therapy, electrodes per pair, paraffin bath, paraffin per pound and manual therapy technique **were not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of 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.

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 09-27-04, 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 **99080-73** date of service 04-02-03 and 05-02-03 denied with U and V codes respectively. The TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$30.00** (\$15.00 X 2 DOS).

CPT code **99213** date of service 05-08-03 denied with denial code "F/Z560" (charge exceeds fee schedule or usual and customary values established by Ingenix). This code is an invalid code as

the service is reimbursed under the 96 Medical Fee Guideline Evaluation/Management GRVI(B). Reimbursement in the amount of **\$48.00** is recommended.

CPT code **99213** date of service 08-06-03 denied with denial code "D/U301" (duplicate invoice). The requestor nor the respondent submitted the original EOB. The Medical Review Division cannot determine the reason for denial. No reimbursement is recommended.

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 Decision is applicable for dates of service 04-02-03 through 08-08-03 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 Findings and Decision and Order are hereby issued this 15th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution
Medical Review Division

DLH/dlh

Enclosure: IRO Decision



Specialty Independent Review Organization, Inc.

October 13, 2004

David Martinez
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-04-2414-01
IRO #: 5284

Specialty IRO 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 Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty 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.

This case was reviewed by a licensed Chiropractor. The Specialty IRO 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 Specialty IRO 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

Ms. ___ is a 54 year old female service representative for _____ who, on ___, slipped outside the cafeteria at work and fell injuring her neck, lower back, right knee, and right upper extremity. She presented to a doctor of chiropractic for physical therapy and, under his referral, also received medical management (prescriptive drug therapy), trigger point injections, epidural steroid injections, biofeedback therapy, and individual psychological counseling. She was eventually determined by a TWCC designated doctor to be at MMI on 02-24-03 with a 5% whole-person impairment.

DISPUTED SERVICES

The disputed services are from 04-02-03 through 08-13-03 and include the following:

Office Visit, Impairment Rating Disability Exam, Myofascial Release, Ultrasound, Electrical Stimulation Unattended, Hot/Cold Pack Therapy, Electrodes Per Pair, Paraffin Bath, Paraffin per Pound, Manual Therapy Technique, Chiropractic Manual Treatment – Spinal

DECISION

The reviewer disagrees with the previous adverse determination for the following services:

Office visit for reevaluation purposes on 04-02-03, Impairment rating disability exam on 04-02-03 and Chiropractic manipulative therapy on 08-08-03.

However, the reviewer agrees with the previous adverse determination for all other services in dispute for 04-02-03 to 08-13-03.

BASIS FOR THE DECISION

Ms. ___ was determined to be at MMI by a TWCC designated doctor on 02-24-03, well before the dates at issue in this dispute even commenced. In his report, and upon his review of the records, the doctor found that the patient's EMG/nerve conduction studies performed on 07-23-02 found "no significant pathology," and that the "x-rays of the knee on 03-14-02 [were] read as normal, x-rays of the cervical spine were read as normal, x-rays of the view of the lumbar spine [showed] no degenerative changes," and "MRI on the lumbar spine on 05-20-02 was read as normal." Following his examination, he opined, "It appears that medical interventions that were proposed by Ms. ___' treating doctors will not materially change her current level of function. She is stable and she is at MMI." Upon review of the subsequent treatment records in this case, the designated doctor's assessment was accurate since the patient's condition did not materially change.

The standard set by Texas Labor Code 408-021 was not met since the treatment did not cure or relieve the effects, did not promote recovery and did not enhance the ability to return to work. According to the "daily treatment logs," this patient's pre-treatment levels of pain on 04-16-03 were 5 out of a possible 10, and then on 08-13-03, they were 7 out of 10 with numbers in between these dates remaining in this range. Ms. ___ also remained off work during that time. Given these facts these services were not medically necessary.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Specialty IRO is forwarding this finding by US Postal Service to the TWCC.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director