

MDR Tracking Number: M5-04-2928-01

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 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on May 7, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. 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.

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 visits, therapeutic activities, gait training, massage, work related or medical disability evaluation rendered on 6/5/03 through 7/11/03 were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 27, 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	MAR\$	Rationale
5/30/03	99080-73	\$15.00	\$0.00	V	\$15.00	The carrier denied CPT Code 99080-73 with a V for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. The requestor submitted relevant information to support delivery of service. Recommend reimbursement in the amount of \$30.00.
7/1/03	99080-73	\$15.00	\$0.00	V	\$15.00	
TOTAL		\$30.00	\$0.00		\$30.00	

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 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 to dates of service 5/30/03 through 7/11/03 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.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

July 23, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-2928-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or

other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: letter of medical necessity, office notes, physical therapy notes, FCE, nerve conduction study and radiology report.

Information provided by Respondent: designated doctor exam.

Clinical History:

The patient was initially injured on the job on _____. She sought appropriate medical care for her injuries and an initial treatment plan consisted of chiropractic manipulation unattended passive physiotherapy modalities. The records indicate the patient responded to the treatment program she received and progressed into an active therapy program. Appropriate diagnostic testing was performed. MRI report revealed left shoulder with tendons intact with fluid present in the glenohumeral joint. Electro-diagnostic testing on 6/5/03 revealed no significant neurological compromise. Functional capacity evaluation test on 6/17/03 revealed overall that the patient had responded to the treatment she received, but she was not able to return to full duty at that time. There were some specific weaknesses that required additional active therapy.

Disputed Services:

Office visits, therapeutic activities, gait training, massage therapy, and work-related or medical disability evaluation.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were medically necessary in this case.

Rationale:

National Treatment Guidelines allow for this type of treatment for this type of injury. There is sufficient documentation on each denied date of service to clinically justify and warrant the ongoing care this patient received. There was clinical justification in this case for the patient to receive a medical disability evaluation by the treating doctor. In conclusion, office visits, therapeutic activities, gait training, massage and work related medical disability evaluation from 6/5/03 through 7/11/03 were, in fact, reasonable, usual, customary, and medically necessary for the treatment of this patient's on the job injury.

Sincerely,