

**THIS MDR TRACKING NO. WAS WITHDRAWN.  
THE AMENDED MDR TRACKING NO. IS: M5-05-1133-01**

MDR Tracking Number: M5-04-3201-01

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 May 24, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the issues of medical necessity. The office visit on 10-08-03 **was** medically necessary. The IRO agrees with the previous determination that the therapeutic exercises, neuromuscular re-education and mechanical traction from 10-08-03 through 10-09-03 **were not** medically necessary. Therefore, the requestor is not entitled to reimbursement of the 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 07-14-04, 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 insurance carrier denied the following services listed on the table below with "F - not according to treatment guidelines". The treatment guidelines were abolished by statute effective 01-01-02; therefore, this review will be per the Medicare Fee Schedule and for dates of services prior to 08-01-03 the review will be per the 1996 Medical Fee Guideline. However, in accordance with rule 133.307 (e)(2)(A) a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with 133.304 (k)(1)(A) were not submitted by the requestor, therefore, no reimbursement is recommend for services listed on table below.

<b>DOS</b>	<b>CPT CODE</b>
05-30-03	99213 97122 97265
06-02-03	99213 97110 97112

	97122 97265
06-03-03	99213 97110 97112 97122 97265
<b>DOS</b>	<b>CPT CODE</b>
06-05-03	99213 97110 97112 97122 97265
06-10-03	99213 97110 97112 97122 97265 99080-73
06-11-03	99213 97110 97112 97122 97265
06-13-03	99213 97122 97265 98940
06-24-04	99213 97122 97265
06-26-03	99213 97110 97112 97122 97265
06-27-03	99213 97110 97112 97122 97265
07-01-03	99213 97110 97112 97122 97265
07-02-03	99213 97110 97112 97122 97265
07-03-03	99213 97110

	97112 97122 97265
07-07-03	99213 97110 97112 97122 97265
<b>DOS</b>	<b>CPT CODE</b>
07-09-03	99213 97110 97112 97122 97265
07-10-03	99213 97110 97112 97122 97265 99080-73
07-15-03	99213 97110 97112 97122 97250
07-17-03	99213 97110 97112 97122
07-22-03	99213 97110 97112 97122
07-23-03	99213 97110 97112 97122
07-25-03	99213 97110 97112 97122
07-30-03	97750
07-31-03	99213 97110 97112 97122 97265
08-01-03	99213 97110 97112 97140

08-05-03	99213 97110 97112 97140
08-07-03	99213 97110 97112 98940 97140
08-08-03	99213 97110 97112 97140
<b>DOS</b>	<b>CPT CODE</b>
08-13-03	99213 97110 97112
08-14-03	99213 97110 97112
08-15-03	99213 97110 97112 97140 99080-73
08-19-03	99213 97110 97112 97140
08-22-03	99213 97110 97112
08-27-03	99213 97110 97112
08-28-03	99213 97110 97112
08-29-03	99213 97110 97112 97140
09-03-03	99213 97110 97112
09-04-03	99213 97110 97112
09-10-03	99213 97110 97112

09-11-03	99213 97110 97112
09-17-03	99213 97110 97112
09-18-03	99213 97110 97112
09-05-03	97750-FCE
09-24-03	99213 97110 97112
09-25-03	99213 97110 97112
<b>DOS</b>	<b>CPT CODE</b>
09-26-03	99213 97110 97112
10-01-03	99213 97110 97112
<b>TOTAL AMOUNT BILLED:</b> \$2903.00	
<b>No Reimbursement recommended.</b>	

### 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 Order is applicable for date of service 10-08-03 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 Order is hereby issued this 10<sup>th</sup> day of November 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division  
PR/pr

07/25/2004

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

Patient:  
TWCC #:  
MDR Tracking #: M5-04-3201-01  
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 with a specialty in Rehabilitation. 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

\_\_\_ was injured on the job on \_\_\_ while lifting a trash bag onto a trash truck for the City of Dallas. He presented to the office of \_\_\_ on 4/8/03. Passive therapies were performed followed by active rehabilitation on 6/11/03. Active rehabilitation was performed from 6/11/03 through 9/26/03. Dr. S performed a peer review/RME on 8/21/03. Notes were included regarding an unknown patient, \_\_\_ by the carrier. A work conditioning program was performed following a denial of work hardening by the carrier. The patient was placed at MMI on 3/30/04 with a 2% WP impairment.

## DISPUTED SERVICES

Disputed services include office visits, therapeutic exercises, neuromuscular re-education and mechanical traction from 10/8/03 through 10/9/03. Additional dates of service were noted to be of a fee dispute nature and are not included in this decision.

## DECISION

The reviewer disagrees with the previous adverse determination regarding the office visit of 10/8/03.

The reviewer agrees with the previous adverse determination regarding all other services.

## BASIS FOR THE DECISION

The reviewer indicates that the provider performed rehabilitative services of exactly the same type and protocol from 6/11/03 through 9/26/03 according to the documentation (rehabilitation exercise card). This is not supportive of continued care as the Guidelines indicate the provider should have changed the protocols for this patient because the patient was not improving with care. Pain scales were relatively unchanged over a five month treatment plan. Passive care cannot be supported at this late date of treatment. Neuromuscular re-education is neither documented in the records supplied nor is it apparently effective; therefore, it cannot be approved. The reviewer indicates the basis for decision is based upon the Mercy Guidelines, ACOEM Guidelines and the Council of Physiological Therapeutics and Rehabilitation Guidelines.

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. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

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.

Sincerely,