

MDR Tracking Number: M5-04-3315-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 6-1-04.

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** 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.

The office visits, manual traction, myofascial release, joint mobilization, manual therapy technique, therapeutic procedure, electrodes, FCE, work related or medical disability examination by treating physician, chiropractic manipulative treatment (spinal one- to two regions) from 7-2-03 through 9-24-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 8-23-04, 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.

In accordance with Rule 129.5, the requestor submitted relevant information to support delivery of service for CPT Code 99080-73 (work status report) on date of service 8-5-03. The TWCC 73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and therefore, recommends reimbursement in the amount of \$15 for date of service 8-5-03 in accordance with the Medical Fee Guidelines. The work status reports for dates of service 7-2-03 and 8-27-03 were not submitted, therefore no reimbursement will be recommended.

Neither the requestor nor the respondents submitted EOB's for CPT Codes 99213 for dates of service 8-26-03, 10-13-03 and 10-20-03; 97140 for date of service 8-26-03 and 97750 for date of service 10-3-03, and did not timely respond to the request for additional information. These dates of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, reimbursement is recommended in the amount of \$198.57 for CPT Code 99213 for dates of service 8-26-03, 10-13-03, and 10-20-03 ($\$54.59 \times 1.25\% = \68.24 MAR). Recommend reimbursement of \$34.05 for CPT Code 97140 (The MAR is \$34.13 however, according to Rule 134.202(d),

reimbursement shall be the least of the (1) MAR amount or the as established by this rule or (2) health care provider's usual and customary charge). Recommend reimbursement of \$37.05 for CPT Code 97750. (The Mar for 15 minutes is \$37.05. There was no information or HCFA's submitted by the requester that would warrant a higher rate of reimbursement.) This is a total reimbursement of \$275.82.

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees:

- 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 dates of service 7-2-03 through 10-20-03 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 1st day of October, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

August 19, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3315-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided

by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ----- external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ----- chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ----- . The patient reported that while at work she injured her low back and left arm when she slipped and fell. The patient was evaluated and initial treatment consisted of physical therapy and chiropractic treatment. A MRI of the lumbar and cervical spine was performed on 7/7/03 indicated a 3mm disc bulge at L4-5 combined with facet hypertrophy, 1-2mm disc bulge at L5-S1, narrowing of thecal sac at L5-S1, degenerative disc changes L4-5 and L5-S1, and straightening and slight reversal of the usual cervical lordosis. Electrodiagnostic studies performed on 7/23/03 demonstrated no neuropathy in relation to plexopathy, polyneuropathy, mononeuropathy, and/or primary muscle disease. The diagnoses for this patient have included cervical disc injury, lumbar sprain/strain, and left elbow sprain/strain. Treatment for this patient's condition has included hot/cold packs, myofascial release, and manual traction.

Requested Services

Office visit (99214 and 99213), manual traction, myofascial release, joint mobilization, manual therapy tech, therapeutic procedure, electrodes, FCE, work related or medical disability examination by treating physician, chiropractic manipulative treatment (spinal, one to two regions from 7/2/03 through 9/24/03).

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Position Letter 7/10/03
2. DDE 10/29/03
3. MRI reports 7/7/03
4. Electrodiagnostic Study report 7/23/03

Documents Submitted by Respondent:

1. Daily Notes 7/2/03 – 10/20/03

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her low back and left arm on -----. The ----- chiropractor reviewer indicated that the patient underwent an MRI on 7/7/03 indicating positive objective findings that correlate with her pain. The ----- chiropractor reviewer explained that this would require ongoing therapy beyond 7/03. The ----- chiropractor reviewer noted that treatment was delayed due to the patient having to undergo cervical cancer surgery. The ----- chiropractor reviewer explained that although this surgery was not a work related compensable injury, it still had a direct affect on her recovery for the work compensable injury. Therefore, the ----- chiropractor consultant concluded that the office visit 99213, manual traction 97122, myofascial release 97250, joint mobilization 97265, office visit 99214, manual traction 97140, electrodes A4556, FCE 97750, VR-Work related or medical disability examination by the treating physician, chiropractic manipulative treatment (CMT) spinal, one to two regions from 7/2/03 through 9/24/03 were medically necessary to treat this patient's condition.

Sincerely,