

MDR Tracking Number: M5-04-3570-01

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 June 22, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the issues of medical necessity. The physical performance tests (97750, 97750-MT) on 07-17-03, 09-11-03 (2x on this date) and 09-04-03, mechanical traction, therapeutic activities, office visits (99211-25) on 08-11-03, 08-13-03, 08-20-03, 08-27-03, 08-29-03, massage therapy, chiropractic manipulation (98943) on 08-13-03, 08-15-03, 08-20-03, 08-22-03, 08-27-03, 09-03-03, and 10-02-03, office visit (99214-25) on 08-15-03 and supplies and materials (99070) on 08-27-03 **were not found** medically necessary. The remainder of the services including office visits (99213, 99214, 99211-25, 99212-25), muscle testing (97750), therapeutic exercises (97110), chiropractic manipulation (98940 & 98943) from 06-30-03 through 09-12-03, **were found** medically necessary. 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-21-04, 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
06-25-03	99070 99070	\$36.66 \$8.00	\$18.33 \$0.00	M F	DOP	1996 MFG Rule 133.1(a)(8)	The requestor submitted documentation that discusses and justifies that the payment amount being sought for the large cryopacks (99070) and analgesic balm (99070) for date of service 06-25-03 is a fair

							and reasonable rate of reimbursement in accordance with Rule 133.1(a)(8). Therefore recommend additional reimbursement of \$26.33.
06-27-03	99214 72110- WP 99070	\$75.00 \$124.00 \$35.00	\$0.00 \$100.00 \$22.42	F F F	\$71.00 \$100.00 DOP	1996 MFG Rule 133.1(a)(8)	The requestor submitted relevant documentation to support services rendered. The 99214 rendered on 06-27-03 will be reviewed in accordance with the 1996 MFG. Recommend reimbursement of 71.00. CPT code 72110-WP was paid in accordance with the 1996 MFG therefore, no additional reimbursement recommended. The requestor submitted documentation that discusses and justifies that the payment amount being sought for the lumbar roll (99070) on date of service 06-27-03 is a fair and reasonable rate of reimbursement in accordance with Rule 133.1(a)(8). Therefore recommend additional reimbursement of \$12.58.
TOTAL							The requestor is entitled to reimbursement of \$109.91

This Findings and Decision is hereby issued this 29th day of October

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

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/or 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 06-25-03 through 10-02-03 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 29th day of October 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/pr

08/23/2004

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

Patient:
TWCC #:
MDR Tracking #: M5-04-3570-01
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 ___ while working for ___. He measures 5'9" and weights 217 pounds according to the records. He has high blood pressure and has a familial history of diabetes. The records indicate he was injured while carrying three pieces of metal angle on his shoulder. He lifted the iron over his head causing pain in his back. Further medical records indicate injuries to his shoulder and thoracic spine. The patient presented to the office of Dr. W, DC on 6/25/03 for

treatment. Passive therapies and active therapies were performed with moderate success. Notes were reviewed by Dr. M, DC, Dr. L, MD, Dr. S, MD and Dr. B, MD. A lumbar MRI was performed on 7/11/03 indicating multilevel lumbar spondylosis, grade 1 anterior spondylolisthesis, mild broad based bulge at L5/S1 and mild facet arthropathy. A right shoulder MRI was performed on 7/22/03 indicating an os acromiale and hypertrophy of the AC joint capsule. A CT scan was recommended for the lumbar spine by the radiologist, this test was performed on 8/12/03 indicating grade 1 spondylolisthesis at L5 with bilateral pars defect, mild bulging disc at L4/5 and L5/S1 yielding mild left foraminal compromise at L4/5 and a posterior disc herniation at L3/4 abutting the L3 nerve root likely resulting in compression of the left L3 nerve root. In March 2004, Dr. O, MD saw the patient for a neurosurgical consult. His notes indicate the performance of a discogram at N. I-45 Diagnostic Center but the report is not present for review. On 4/5/04, Dr. O performed a L5 laminectomy for decompression, bilateral L5/S1 facetectomies, L5 through S1 posterior lumbar interbody fusion with allograft bone, L5 through S1 pedicle screw instrumentation with posteriolateral arthrodesis and right iliac crest autograft.

DISPUTED SERVICES

Disputed services in this case include the following: office visits (99211-25, 99212-25, 99213, 99214, 99214-25), therapeutic exercises- 97110, 97750 (97750-MT) Physical performance test, 97150 therapeutic procedures (group), 97012 (mechanical traction), 98940 chiropractic manipulation, 98943 extremity manipulation, 95851- ROM, 99070 supplies and 97124 (massage). As denied by the carrier with a "u" code regarding DOS 6/30/03 through 10/2/03. Fee disputes are noted for dates of service 6/25/03 through 6/27/03, 8/29/03 (98943), 9/3/03 (97150) and 9/12/03 (99070).

DECISION

The reviewer agrees with the previous adverse determination regarding the following services: **97750-MT** (7/17/03, 9/11/03 (times two on this date of service), **97750** (9/4/03), **97012** (all dates of service), **97150** (all dates of service), **99211-25** (8/11/03, 8/13/03, 8/20/03, 8/27/03, 8/29/03), **97124** (all dates of service), **98943** (8/13/03, 8/15/03, 8/20/03, 8/22/03, 8/27/03, 9/3/03, 10/2/03), **99214-25** (8/15/03) and **99070** (8/27/03).

The reviewer disagrees with the previous adverse determination regarding all remaining services.

BASIS FOR THE DECISION

The reviewer notes that the patient presented for treatment in a timely manner and the approved treatment procedures were within normal limits as per the Council of Chiropractic Physiological Therapeutics and Rehabilitation Guidelines. The reviewer notes the care was denied during the acute phase of care in an accepted workers' compensation claim. The reviewer states that the passive therapies were not medically necessary as they tend to lead to physician dependence. The functional testing was necessary as approved to determine progress in the patient's active rehabilitation protocols. The group therapeutic procedures were denied as the patient was given

two hours of rehabilitation sessions on many visits and this is the maximum that is available per the TWCC Guidelines and accepted treatment Guidelines (CCPTR). Both office visits and manipulations cannot be performed as per Medicare Guidelines on the same visit. The Evidence Based Medical Guidelines indicate that active rehabilitation is medically appropriate in the subacute and chronic phases of treatment. The reviewer notes the usage of The database of abstracts of reviews of effectiveness (University of York), Database no.: DARE-983339. In: The Cochrane Library, Issue 2, 2000.)

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,