MDR Tracking Number: M5-04-3980-01

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 7-21-04.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 7-21-04, therefore the following date(s) of service are not timely and are not eligible for this review: 5-31-03 through 7-16-03.

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

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 (except for date of service 8-6-03), office visits with manipulation, hot-cold packs, electrical stimulation unattended, ultrasound, joint mobilization, myofascial release, chiropractic manipulative treatment, manual therapy technique, massage, cervical pillow, traction equipment, and therapeutic activities from 7-21-03 through 5-14-04 were **found** to be medically necessary. The office visit on date of service 8-6-03 and all vasopneumatic treatments from 7-21-03 through 5-14-04 **were not** found to be medically necessary.

On August 16, 2004, the Medical Review Division submitted a Notice to the 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 Codes 98941, 97035, 97140 for 10-3-03 were billed by the requestor and denied by the carrier. Neither the requestor nor the respondents submitted EOB's 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. CPT Code 98941 will be reimbursed at $43.89. CPT Code 97035 will be reimbursed at $15.30. CPT Code 97140 will be reimbursed at $32.55. **Total reimbursement is $91.74.**

- The MAR for CPT Code 99214 for 10-8-03 is $98.10. 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 $80.00.**

- CPT Code 97001 for date of service 5-5-04 was billed by the requestor and denied by the carrier. Neither the requestor nor the respondents submitted an EOB and did not timely respond to the request for additional information. This date 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 $92.21**.

This Findings and Decision is hereby issued this 8th day of October 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

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 the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;

- 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 7-21-03 through 5-14-04 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.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/da

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

September 22, 2004

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-3980-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 44 year-old female was injured on ___ when she was involved in a high-speed automobile accident. She is not a surgical candidate and she has been treated with chiropractic modalities, medications, and epidural steroid injections for neck and shoulder pain since the date of the injury.

Requested Service(s)

Office visits, office visits with manipulation, hot/cold packs, electrical stimulation unattended, vasopneumatic treatment, ultrasound, joint mobilization, myofascial release, chiropractic manipulative treatment, manual therapy technique, massage, cervical pillow, traction equipment, and therapeutic activities for dates of service 07/21/03 through 05/14/04.

Decision

It is determined that the office visit on 08/06/03 and all vasopneumatic treatments from 07/21/03 through 05/14/04 were not medically necessary to treat this patient's medical condition.

However, office visits (except 08/06/03), office visits with manipulation, hot/cold packs, electrical stimulation unattended, ultrasound, joint mobilization, myofascial release, chiropractic manipulative treatment, manual therapy technique, massage, cervical pillow, traction equipment, and therapeutic activities were medically necessary to treat this patient's medical condition from 07/21/03 through 05/14/04.

Rationale/Basis for Decision

There is adequate documentation of objective and functional improvement to warrant continued treatment. Specifically, the patient's pain ratings significantly decreased and her spinal ranges of motion increased to near normal. Without question, the medical records fully substantiate that the disputed services fulfilled the statutory requirements since the patient obtained relief, promotion of recovery was accomplished, and there was an enhancement of the employee's ability to return to or retain employment. Therefore, the office visits (except 08/06/03), office visits with manipulation, hot/cold packs, electrical stimulation unattended, ultrasound, joint mobilization, myofascial release, chiropractic manipulative treatment, manual therapy technique, massage, cervical pillow, traction equipment, and therapeutic activities were medically necessary in the treatment of the patient.

However, the medical records do not support the medical necessity of the comprehensive and complex examination performed on 08/06/03, nor the vasopneumatic treatment from 07/21/03 through 05/14/04.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn

Attachment

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-04-3980-01

Information Submitted by Requestor:

- Appeal letter
- Designated doctor evaluation
- Peer review
- Treatment notes/Chiropractic
- Office note/Neurology
- Office notes Pain management
- MRI report
- Epidural steroid injection reports

Information Submitted by Respondent: