

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, 133.307 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 10-22-04.

Date of service 10-20-03 per Rule 133.308(e)(1) was not timely filed and will not be reviewed by the Medical Review Division.

The IRO reviewed office visits, therapeutic exercises, manual therapy technique, muscle test whole body and ROM measurement extremity or trunk rendered from 10-23-03 through 12-05-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 11-19-04, 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.

Review of CPT code 99213 date of service 02-02-04 revealed that neither party submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement recommended.

CPT code 99213 dates of service 02-12-04 and 03-01-04 denied with denial codes "N/TG and N/JF" (documentation does not support services billed). The requestor did not submit documentation for review. Per Rule 133.307(g)(3)(B) no reimbursement is recommended.

CPT code 95834 date of service 03-09-04 denied with denial code "G" (global). Per Rule 133.304(c) the carrier did not specify which service code 95834 was global to. Review will be per the Medicare Fee Schedule. The MAR per the Medicare Fee Schedule is \$51.83 (\$41.46 X 125%). The requestor only billed \$45.00 therefore this is the recommended reimbursement.

CPT code 99215 date of service 03-18-04 denied with denial code "N/TG" (documentation does not support services billed). The requestor did not submit documentation for review. Per Rule 133.307(g)(3)(B) no reimbursement is recommended.

CPT code 99080-73 date of service 03-18-04 denied with denial code "F" (fee guideline MAR reduction). Reimbursement per Rule 129.5 is recommended in the amount of \$15.00.

## 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 Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 03-09-04 and 03-18-04 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 Findings and Decision and Order are hereby issued this 20th day of January 2005.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh  
Enclosure: IRO Decision

### **IRO Medical Dispute Resolution M5 Retrospective Medical Necessity IRO Decision Notification Letter**

Date: 1/7/2004  
Injured Employee:  
MDR : M5-05-0611-01  
TWCC #:  
MCMC Certification #: 5294

DETERMINATION: Deny

Requested Services:  
Please review the item in dispute regarding 99211-Office Visit Level,  
97110-Therapeutic Exercises, 97140-Manual Therapy Technique,  
95833-Muscle Test Whole Body, 95851-ROM Measurement Extremity or Trunk.

Dates of Service in Dispute: 10/23/2003 to 12/05/2003

MCMC llc (MCMC) is an Independent Review Organization (IRO) that was selected by The Texas Workers' Compensation Commission to render a recommendation regarding the medical necessity of the above Requested Service.

Please be advised that a MCMC Physician Advisor has determined that your request for M5 Retrospective Medical Dispute Resolution on 11/19/2004, concerning the medical necessity of the above referenced requested service, hereby finds the following:

The medical necessity for the application of the services listed above is not established for the dates of service from 10/23/2003 through 12/05/2003.

This decision is based on:

\*TWCC Notification of IRO Assignment

\*TWCC-60 10 pgs

\*Alternate TWCC-62 stamped received 12/19/2003 17 pgs.

Records indicate that the above captioned individual was injured as a result of an on the job incident. The date of injury is \_\_\_\_\_. The injured worker has been receiving chiropractic care to include passive and active therapy from on or before 10/23/2003 through at least 12/05/2003.

The documentation suggests that the injured worker underwent surgery, however the date is not known.

There is no supporting documentation to establish that the injured worker was benefiting from the course of care offered by the treating physician. There is no documentation provided to include or reveal an initial examination, daily SOAP notes, functional or diagnostic testing, progress reports, or follow up examinations. Without these specific entities of documentation, the medical necessity and appropriateness of the services captioned above during the above-specified dates of service cannot be established. Furthermore, there is no information contained within the documentation to indicate why continuing conservative care is necessary some three plus years post injury. This continued conservative intervention is inconsistent with generally accepted standards of care within the chiropractic profession as listed below.

**REFERENCES:**

1. The North American Spine Society Guidelines
2. ACOEM Guidelines
3. Milliman and Robertson Vol. 7, Guidelines for Chiropractic Quality Assurance and Practice Parameters
4. Practice Parameters from the proceedings of the Mercy Center Consensus Conference, Agency for Health Care Policy and Research (AHCPR)
5. Procedural Utilization Guidelines.

The reviewing provider is a Licensed Chiropractor and certifies that no known conflict of interest exists between the reviewing Chiropractor and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO. The reviewing physician is on TWCC's Approved Doctor List.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5).

**In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of TWCC on this**

**7<sup>th</sup> day of January 2005.**

**Signature of IRO Employee:** \_\_\_\_\_

**Printed Name of IRO Employee:** \_\_\_\_\_