

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 03-21-05.

The IRO reviewed chiropractic manipulative treatment, massage therapy, therapeutic activities, ultrasound and office visit rendered from 08-30-04 through 10-06-04 that were denied based upon "V".

The IRO determined that the office visit **was not** medically necessary and the chiropractic manipulative treatment, massage therapy, therapeutic activities and ultrasound **were** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of 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 \$460.00** 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. The amount due from the carrier for the medical necessity issues equals **\$1,536.24**.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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 for dates of service 08-30-04 through 10-06-04 totaling 1,536.24 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 Findings and Decision and Order are hereby issued this 13th day of June 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 31, 2005

To The Attention Of:

TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker: _____
MDR Tracking #: M5-05-2028-01
IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed 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 Chiropractic reviewer who has an ADL certification. The reviewer 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Rebuttal letter
- Impairment reports
- TWCC 69 reports
- Initial evaluation
- Daily notes

Submitted by Respondent:

- Statement letter from carrier
- Designated Doctor Exam
- Daily Notes
- Peer Review

Clinical History

According to the supplied documentation, it appears that the claimant sustained an injury to her bilateral knees and low back when she tripped at work on _____. She reported to her treating doctor 2 days later for evaluation and therapy. The claimant began passive therapy. The claimant underwent therapy from 08/09/2004 – 10/11/2004. On 10/11/2004 her treating doctor assigned a whole person impairment of 9%. A designated doctor exam was performed on 12/21/2004 that gave the claimant a 0% whole person impairment with MMI occurring on 10/11/2004. The documentation ends here.

Requested Service(s)

98940 - chiropractic manipulative treatment, 97124 - massage, 97530 - therapeutic activities, 97035 - ultrasound, and 99215 - office visit for dates of service 8/30/2004 to 10/6/2004

Decision

I agree with the insurance carrier that the evaluation code 99215 was not medically necessary. I disagree with the carrier and agree with the provider that the remainder of services rendered were medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, the claimant sustained a sprain/strain injury to her low back on _____. The claimant also sustained a contusion, bilaterally to her knees with a laceration. According to the Official Disability Guidelines 9th ed page 1138, “with evidence of objective functional improvement, a total of 18 visits over a 6-8 weeks” is the standard for chiropractic guidelines. The therapy and treatment falls within this guideline and is considered reasonable for the type of injury sustained. The documentation supplied reveals that the carrier allowed for 2 weeks of treatment and then denied care beyond that date. This is not in line with current treatment protocols. The therapy in question appears to begin with passive care, transition to active care while reducing frequency. All of the therapy is considered medically necessary. The office evaluation code billed as 99215 was not objectively supported by the documentation submitted. The amount of time and documentation do not correlate with the injury and medical decision making of a 99215 CPT code.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 31st day of May 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder