MDR Tracking Number: M5-03-0064-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 chiropractic treatment from 9-20-01 through 11-13-01 were found to be medically necessary.

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 $460.00** 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.

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.

On March 20, 2003, 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 that were denied based upon EOB denial code, "G" and the Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
9-21-01 10-9-01 10-23-01	95851	$36.00	$0.00	G	$36.00	CPT Code description	On these dates, the requestor provided office visit and physical therapy services, Range of Motion testing is not global to these services. Reimbursement of 3 X $36.00 = $108.00.

9-25-01 10-10-01 10-24-01	97750 MT	$43.00	$0.00	G	$43.00		On these dates, the requestor provided office visit and physical therapy services, Muscle testing is not global to these services. Reimbursement of 3 X $43.00 = $129.00.
TOTAL		$237.00					The requestor is entitled to reimbursement of $237.00.

This Decision is hereby issued this 18th day of July 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the espondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) 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 to dates of service 9-20-01 through 11-13-01 in this dispute.

This Order is hereby issued this 18th day of July 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

December 5, 2002

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-0064-01
IRO Certificate #: 4326

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

___ 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. ___ 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 ___ 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 30 year old male sustained a work-related injury on ___. The origin or specific nature of the injury was not identified in the information submitted for review. The patient received chiropractic treatments, from 09/20/01 through 11/13/01 for thoracic disc disorder, muscle spasms and thoracic radiculitis/neuritis.

Requested Service(s)

Chiropractic treatments from 09/20/01 through 11/13/01

Decision

It has been determined that the chiropractic treatments from 09/20/01 through 11/13/01 were medically necessary.

Rationale/Basis for Decision

According to the medical records, the patient was injured on ___. Objective findings showed fixation in the thoracic spine region along with muscle spasms and decreased range of motion. The procedures performed included joint mobilization, manipulation, therapeutic exercises, myofascial release and manual traction. All of the therapies and testing were performed within the acute to sub-acute stage of the injury and were used to correct the objective symptoms of the patient. Therefore, the chiropractic treatments from 09/20/01 to 11/13/01 were medically necessary.

Sincerely,