THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-0140.M5

MDR Tracking Number: M5-03-0369-01

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 IRO reviewed chiropractic treatment rendered from 10-11-01 to 12-17-01 that were denied based upon "U" or "T".

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(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** 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 January 3, 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 and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
7-30-01 8-1-01 8-3-01 8-29-01 11-16-01 11-20-01 11-21-01 12-7-01 12-12-01 12-14-01	97110	$140.00	$0.00	N	$35.00/ 15 min	Medicine GR (I)(A)(9)(b) (I)(C)(9) (I)(A)(11)(a)	Documentation does not support billed service. 1 to 1 supervision is not documented. Reimbursement is not recommended.
7-20-01 12-5-01 12-10-01	97110	$105.00	$0.00	N	$35.00/ 15 min	Medicine GR (I)(A)(9)(b) (I)(C)(9)	Documentation does not support billed service. 1 to 1 supervision is not documented. Reimbursement is

12-19-01 12-21-01						(I)(A)(11)(a)	not recommended
7-23-01 7-25-01 7-27-01 9-4-01 9-6-01	97110	$175.00	$0.00	N	$35.00/ 15 min	Medicine GR (I)(A)(9)(b) (I)(C)(9) (I)(A)(11)(a)	Documentation does not support billed service. 1 to 1 supervision is not documented. Reimbursement is not recommended
7-9-01 7-11-01 7-13-01 7-18-01 8-29-01	97035	$25.00	$0.00	N	$22.00	CPT Code description	Documentation supports billed service. Reimbursement is recommended of 5 X $22.00 = **$110.00**.
11-16-01 12-10-01	97265	$45.00	$0.00	N	$43.00	CPT Code description	Documentation supports billed service. Reimbursement is recommended of 2 X $43.00 = **$86.00**.
7-9-01 7-11-01 7-13-01 7-16-01 7-18-01 8-3-01 8-8-01 8-15-01 8-29-01 9-4-01 9-6-01 11-16-01 11-20-01 11-21-01 12-7-01 12-12-01 12-14-01 12-19-01 12-21-01	97250	$43.00	$0.00	N	$43.00	CPT Code description	Documentation supports billed service. Reimbursement is recommended of 19 X $43.00= $**817.00**.
7-9-01 7-11-01 7-13-01 7-16-01 7-18-01 7-20-01 7-30-01 8-3-01 8-8-01 8-15-01 8-29-01 9-4-01 9-6-01 11-16-01 11-20-01 11-21-01 12-7-01 12-10-01 12-12-01 12-14-01 12-19-01 12-21-01	97014	$15.00 $20.00	$0.00	N	$15.00	CPT Code description	Documentation supports billed service. Reimbursement is recommended of 22 X $15.00 = $**330.00.**

7-9-01 7-11-01 7-13-01 7-16-01 7-18-01 7-20-01 7-30-01 8-3-01 8-8-01 8-15-01 9-4-01 9-6-01 11-20-01 12-7-01 12-12-01 12-14-01 12-19-01 12-21-01	97010	$11.00 $20.00	$0.00	N	$11.00	CPT Code description	Documentation supports billed service. Reimbursement is recommended of 18 X $11.00 = **$198.00**
11-20-01	99080-73	$15.00	$0.00	N	$15.00	Rule 129.5(d)	A TWCC-53 was submitted dated 10-24-01. A report for 11-20-01 was not submitted. Reimbursement is not recommended.
7-9-01 7-24-01 7-27-01 9-6-01 11-21-01 12-7-01 12-21-01	99212	$35.00	$0.00	N	$32.00	CPT Code description	Documentation supports billed service. Reimbursement is recommended of 7 X $32.00 = **$224.00.**
7-11-01 7-13-01 7-16-01 7-18-01 7-20-01 7-23-01 7-25-01 7-30-01 8-1-01 8-6-01 8-29-01 9-4-01 12-5-01 12-10-01 12-14-01 12-19-01	99213 99213MP	$50.00	$0.00	N	$48.00	CPT Code description	Documentation supports billed service. Reimbursement is recommended of 16 X $48.00 = $**768.00.**
7-25-01 7-30-01 12-5-01	97261	$8.00	$0.00	N	$8.00	CPT Code description	Documentation supports billed service. Reimbursement is recommended of 3 X $8.00 = **$24.00.**
8-3-01	99214	$75.00	$0.00	N	$71.00	CPT Code description	Documentation supports billed service. Reimbursement is recommended of **$71.00**
TOTAL							The requestor is entitled to reimbursement of **$2628.00.**

This Decision is hereby issued this 21st day of July 2003.

Elizabeth Pickle
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) 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 7-9-01 through 12-21-01 in this dispute.

In accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee.

This Order is hereby issued this 21st day of July 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

November 21, 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 #: M5-03-0369-01
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 43 year old female sustained a work-related injury on ___. She was leaning over a table cutting fabric when she felt a pull from her low back up to her neck. She subsequently complained of pain in her back, shoulder and neck as well as right leg numbness. The clinical and diagnostic work-up revealed lumbar disc herniation, lumbar radiculopathy, torn rotator cuff of the right shoulder, cervical sprain/strain and post-traumatic cervical radiculopathy. The plan of care has included rotator cuff repair on 09/26/01, physical therapy, epidural steroid injections, medications, including non-steroidal anti-flammatory medication. In addition, the patient had chiropractic treatment from 10/11/01 through 12/17/01.

Requested Service(s)

Chiropractic treatment from 10/11/01 through 12/17/01

Decision

It has been determined that the chiropractic treatment from 10/11/01 through 12/17/01 was medically necessary.

Rationale/Basis for Decision

The patient sustained a work-related injury on ___ to her neck, back and shoulder. MRI scans revealed lumbar disc herniation and full thickness rotator cuff tear of the right shoulder. Neurodiagnostics revealed lumbar radiculopathy. The patient underwent arthroscopic shoulder repair on 09/26/01. The chiropractic treatment from 10/11/01 – 12/17/01 was an essential component of post surgical rehabilitation and was in accordance with industry accepted rehabilitation protocol for restoration of function. Therefore, the chiropractic treatment from 10/11/01 through 12/17/01 was medically necessary.

Sincerely,