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

SOAH DOCKET NO. 453-03-3357.M5

MDR Tracking Number: M5-03-0878-01

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 Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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. There are unresolved fee issues.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
6/12/02 7/1/02 7/2/02	99213	$ 48.00 x 34 = $1,632.00	$144.00	U	$ 48.00	IRO decision	The IRO determined these services were not medically necessary; therefore, no reimbursement is recommended.
7/5/02 7/8/02 through 7/11/02 7/15/02 7/16/02	97110	$140.00 x 7 = $980.00 $175 x 24 = $4,200.00			$35.00 ea 15 min		
7/18/02 7/19/02 7/22/02	97250	$43.00 x 32 = $1,376.00			$43.00		
through 7/25/02 7/29/02	97265	$43.00 x 32 = $1,376.00			$43.00		
through 8/1/02 8/5/02	95851	$36.00 x 4 = $144.00			$36.00 ea extrem		
through 8/8/02 8/12/02	97750-MT	$43.00 x 4 = $172.00	$86.00		$43.00		
through 8/15/02	95904WP	$64.00 x 2 =			$64.00 ea nerve		

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
8/19/02 through 8/22/02 8/26/02 9/9/02		$128.00					
8/21/02	99213	$48.00	0.00	D	$48.00	96 MFG E/M GR VI B	Neither party submitted the original EOB; therefore, review per the MFG. Office notes support services rendered. Recommend reimbursement of $48.00.
TOTAL		$10,008	$230.00				The requestor is entitled to reimbursement of $48.00.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay $48.00 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 to dates of service 6-12-02 through 9-9-02 in this dispute.

This Order is hereby issued this 16th day of April 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division
DZT/dzt

February 10, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-03-0878-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ provided care for his patient, ___, from 6/12/02 through 9/9/02 for an injury that occurred ___. The carrier has denied payment for all treatment during this period.

DISPUTED SERVICES

Under dispute is the medical necessity of office visits, therapeutic procedures, analysis/computer data, myofascial release, joint mobilization, range of motion, muscle testing, usual travel, temperature gradient study, and sense nerve root conduction testing for this patient from 6/12/02 through 9/9/02.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

___ diagnosed this patient with cervical disc disorder, nerve root injury, headache and muscle spasms on his initial exam. He noted that ___ returned from his visit with ___, but no report was included. ___ also noted the need for neurological testing, but it appears none was performed.

Throughout the treatment in question, the patient's subjective and objective symptoms never changed. Certainly during this period further testing and evaluation should have been done, but the reviewer cannot find any evidence in the record that was provided. As a result of this lack of evidence, this treatment is deemed unnecessary.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,