MDR Tracking Number: M5-03-1103-01

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 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 12-31-02.

The IRO reviewed office visits and physical therapy rendered from 1-10-02 to 1-17-02 that were denied based upon “U”.

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 $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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On March 5, 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:

Services that were denied without an EOB will be reviewed in accordance with *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
1-4-02 1-10-02 1-23-02	99213	$48.00	$0.00	F	$48.00	Evaluation & Management GR (IV)	Office visits report supports reimbursement per MFG, 3 dates X $48.00 = $144.00.
1-4-02 1-10-02 1-23-02	97265	$43.00	$0.00	F	$43.00	CPT Code description	SOAP note supports reimbursement per MFG, reimbursement is recommended of 3 dates X $43.00 = $129.00.

1-4-02 1-10-02 1-23-02	97250	$43.00	$0.00	F	$43.00	CPT Code description	SOAP note supports reimbursement per MFG, reimbursement is recommended of 3 dates X $43.00 = $129.00.
1-4-02 1-10-02 1-23-02	97122	$35.00	$0.00	F	$35.00	CPT Code description	SOAP note supports reimbursement per MFG, reimbursement is recommended of 3 dates X $35.00 = $105.00.
1-4-02 1-10-02 1-23-02	97110 (4 units)	$135.00	$0.00	F	$35.00/ 15 min	Medicine GR (I)(A)(9)(b)	Documentation does not support billed service. 1 to 1 supervision is not documented. Reimbursement is not recommended.
1-10-02	95851	$36.00	$0.00	F	$36.00	CPT Code description	Lumbar ROM report supports billed service. Reimbursement is recommended of $36.00.
TOTAL							The requestor is entitled to reimbursement of **$543.00.**

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 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 1-4-02 through 1-23-02 in this dispute.

This Decision and Order is hereby issued this 7th day of October 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

February 27, 2003 **Revised**

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

MDR Tracking #: M5 03 1103 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.

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

This patient suffered an injury to the lumbar spine on her job and sought treatment from ___. The injury was initially diagnosed as a disc herniation. MRI revealed that there was a bulge at L5-S1 along with the possibility of a compression of the S1 segment. The treating doctor initiated a treatment plan to include passive and then active treatment to the lumbar spine. The treatment rendered was completed by January 28. 2002 and the patient was returned to work after 8 weeks of therapy. A review was performed by ___ on March 20, 2003 in which he stated that the care rendered was extensive and that she had not had diagnostics regarding this case. MRI was actually performed on January 3, 2002. ___ stated that these injuries typically heal themselves in 6-8 weeks. He indicated that she needed to return to work, but the patient has apparently been back at work for 2 full months upon his review.

DISPUTED SERVICES

The carrier denies the medical necessity of office visits, joint mobilization, myofascial release, therapeutic procedures, manual traction and temperature gradient studies as medically unnecessary. The IRO is asked to review January 10th and January 17th, 2002.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The care rendered was performed in a relatively efficient fashion. The patient returned to work and was released after 8 weeks of care in spite of what could have been a more serious injury that initially believed. The treating doctor delivered good quality care on the dates of service in question and it was rendered with indications that the patient was getting relief from the pain and results from the prescribed treatment. The review doctor apparently did not have the full documentation available to him, as he was in the dark regarding the MRI as well as the patient's work status. He stated that injuries such as this

heal themselves in 6-8 weeks. This is true, but the treating doctor's program was within that timeframe and clinically, this treatment easily falls to within the parameters of the Texas Guidelines for Quality Assurance.

___ 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,