MDR Tracking Number: M5-03-1194-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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 1-16-03.

The IRO reviewed physical therapy and office visits rendered from 6-3-02 to 7-11-02 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(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.

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

On March 31, 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
6-3-02	99213	$73.00	$0.00	F	$48.00	Evaluation & Management GR (IV)	SOAP note supports billed service per MFG, reimbursement of $48.00 is recommended.
6-6-02	99213	$73.00	$0.00	No EOB	$48.00		SOAP note for 6-6-02 was not submitted to support service billed; therefore, reimbursement is not
6-6-02	97032 (X2)	$50.00	$0.00	No EOB	$22.00 / 15 min	CPT Code description	

6-6-02	97035 (X2)	$50.00	$0.00	No EOB	$22.00 / 15 min	CPT Code description	recommended.
6-6-02	97012	$23.00	$0.00	No EOB	$20.00	CPT Code description	
6-6-02	97250	$45.00	$0.00	No EOB	$43.00	CPT Code description	SOAP note for 6-6-02 was not submitted to support service billed; therefore, reimbursement is not recommended.
TOTAL							The requestor is entitled to reimbursement of **$48.00.**

This Decision is hereby issued this 15th day of October 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 6-3-02 through 07-11-02 in this dispute.

This Order is hereby issued this 15th day of October 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 18, 2003

Requester/ Respondent Address : Rosalinda Lopez
TWCC
4000 South IH-35, MS-48
Austin, Texas 78704-7491

RE:
MDR Tracking #: M5-03-1194-01
IRO Certificate #: **5242**

___ 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 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.

A matched peer performed the independent review with the treating health care provider. Your case was reviewed by a chiropractor. The chiropractic physician reviewer has signed a statement acknowledging that there are no conflicts of interest in relation to himself and the treating doctor and/or the patient. The reviewer has also certified that the review has no bias toward or against either party.

The reviewer has based his decision upon the evidence solely from the medical records received. The reviewer has never performed any exam on the patient. All determinations were based on the submitted records.

Clinical History

According to the documentation supplied, ___ fell at her job on ___. She immediately had complaints of low back pain and right wrist pain. She went to ___ for evaluation. She began treatment with chiropractic care. A MRI revealed small herniations at multiple levels. A NCV showed bilateral L5 nerve root irritation. The patient was referred to ___ for evaluation and medications. On 07/18/2002 a BRC was held and it was mutually agreed that the claimant had a compensable injury, did not willfully injure herself, and that she did sustain a disability from her 05/02/2002 work injury. On 08/20/2002, ___ performed an IME. ___ reported that the claimant was at MMI and that her care up to that point had been more or less appropriate. On 09/08/2002, ___ performed a peer review. ___ stated that 6-8 weeks of active therapy as well as adjustments would be reasonable and medically necessary.

Requested Service(s)

Please review and address the medical necessity of the outpatient services rendered 06/03/2002-07/11/2002, including PT and office visits.

Decision

I disagree with the insurance company and find the physical therapy and office visits rendered between 06/03/2002 and 07/11/2002 medically necessary

Rationale/Basis for Decision

After careful consideration of all the documentation submitted, I reviewed both the independent medical examination and peer review physicians' reports. Both of them felt that this amount of

care was within guidelines. The treatment period in question is within 8 weeks, which both physicians stated was reasonable. ___ stated that the treatment was more or less appropriate. ___ stated that active care and chiropractic adjustments were allowed within the first 6-8 weeks of treatment.

This decision by the IRO is deemed to be a TWCC decision and order.

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 20th day of March 2003.