MDR Tracking Number: M5-03-1277-01

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 1-23-03.

Date of service 1-16-03 was submitted untimely per above referenced rule and will not be considered in this decision.

The IRO reviewed chiropractic treatment rendered from 1-16-02 through 10-11-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO concluded that the office visit with manipulation, myofascial release and electrical stimulation from 1-25-02 through 5-22-02 were medically necessary. The neuromuscular reeducation, therapeutic procedures and physical medicine treatments from 1-25-02 through 5-22-02 were not medically necessary.

On this basis, the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 May 30, 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
5-24-02 5-28-02 7-26-02 9-13-02 9-30-02 10-11-02	99213MP	$48.00	$0.00	No EOB	$48.00	Rule 133.307(g)(3)	The requestor did not submit medical records to support billed service in accordance with MFG; therefore, no reimbursement is recommended.
5-24-02 5-28-02	97110 (X3_	$105.00	$0.00	No EOB	$35.00 / 15 min		
9-30-02	99455	$250.00	$0.00	No EOB	See Evaluation & Management GR XXII		
TOTAL							The requestor is not entitled to reimbursement.

This Decision is hereby issued this 3rd day of November 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 1-25-02 through 10-11-02 in this dispute.

This Order is hereby issued this 3rd day of November 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

April 25, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1277-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 47 year-old male who sustained a work related injury on ___. The patient reported that while at work he was attempting to hook a crane cable to a large drill. The patient's arm was caught in the cable and the patient was picked up off the ground and slammed back onto the ground. The patient was treated by a chiropractor with interferential current, ice and myofascial trigger point release therapy, and spinal manipulations. The patient underwent an MR and was then referred for epidural steroid injections. MRI of the cervical spine showed C5-6 disc bulge and a 3mm disc bulge at the C4-5 and C6-7 level. The patient was referred for pain management, Behavioral Services and a work hardening program. The patient participated in work hardening for approximately 6-8 weeks.

Requested Services

Office visits with manipulations, neuromuscular reeducation, therapeutic procedure, myofascial release, electrical stimulation and physical medicine treatment from 1/25/02 through 5/22/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 47 year-old male who sustained a work related injury to his back on ___. The ___ chiropractor reviewer also noted that the patient was diagnosed with a 3mm disc bulge at the C4-5 and C6-7 level. The ___ chiropractor reviewer indicated that the patient was treated with manipulations, neuromuscular reeducation, therapeutic procedures, myofascial release, electrical stimulation and physical medicine treatments from 1/25/02. However, the ___ chiropractor reviewer explained that the medical records provided do not support the neuromuscular reeducation, therapeutic procedures or physical medicine treatment rendered to this patient. The ___ chiropractor reviewer noted that the patient was referred to several specialists. The ___ physician reviewer explained that the patient received no other treatment other than the manipulations rendered by the treating chiropractor. The ___ chiropractor reviewer explained that the patient showed considerable improvement with the documented treatments of manipulations and myofascial release from 1/8/02 through 7/15/02.

Therefore, the ___ chiropractor consultant concluded that the office visits with manipulations, myofascial release and electrical stimulation from 1/25/02 through 5/22/02 were medically necessary to treat this patient's condition. However, the ___ chiropractor consultant concluded that the neuromuscular reeducation, therapeutic procedures and physical medicine treatments from 1/25/02 through 5/22/02 were not medically necessary to treat this patient's condition.

Sincerely,