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

SOAH DOCKET NO. 453-03-4396.M5

MDR Tracking Number: M5-03-1335-01

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 **or January 1, 2003** 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 office visits and physical therapy rendered from 7-30-02 to 9-6-02 denied based upon "U" were found to be medically necessary.

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.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 to dates of service 7-30-02 through 9-6-02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

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.

The following table identifies the disputed services that were denied based upon EOB denial code, "F" and "No EOB", and the Medical Review Division's rationale:

Services denied based upon "No EOB" will be reviewed in accordance with the Commission's *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
7-29-02 8-19-02 8-23-02	99080-WC	$170.00 $150.00 $130.00	$50.00 $0.00 $0.00	F			

9-20-02		$130.00	$0.00				
8-23-02 9-20-02	99080-73	$15.00	$0.000	No EOB	$15.00		
8-5-02 8-6-02 8-7-02 8-8-02 8-12-02 8-13-02 8-15-02 8-16-02 8-19-02 8-20-02 8-22-02 9-16-02 9-18-02	99213-MP	$55.00	$0.00	No EOB	$48.00	Medicine GR (I)(B)(1)(b)	Documentation supports billed service. Reimbursement per MFG is recommended. 13 X $48.00 = $624.00
8-5-02 8-6-02 8-7-02 8-8-02 8-12-02 8-13-02	97032	$30.00	$0.00	No EOB	$22.00	Medicine GR (I)(A)(10)(a)	Documentation supports billed service. Reimbursement per MFG is recommended. 6 X $22.00 = $132.00
8-5-02 8-7-02 8-12-02 8-13-02	97012	$25.00	$0.00	No EOB	$20.00	Medicine GR (I)(A)(10)(a)	Documentation supports billed service. Reimbursement per MFG is recommended. 4 X $20.00 = $80.00
8-13-02 8-15-02 8-20-02 8-22-02	97112	$50.00	$0.00	No EOB	$35.00	Medicine GR (I)(A)(9)(b) (I)(C)(9)	Documentation does not support one to one supervision per MFG. No reimbursement is recommended.
8-5-02 8-6-02 8-7-02 8-8-02 8-12-02 8-15-02 8-16-02 8-19-02 8-20-02 8-22-02 9-16-02 9-18-02	97250	$50.00	$0.00	No EOB	$43.00	Medicine GR (I)(A)(10)(a)	Documentation supports billed service. Reimbursement per MFG is recommended. 12 X $43.00 = $516.00
8-5-02 8-6-02	97265	$45.00	$0.00	No EOB	$43.00	Medicine GR	Documentation supports billed

8-7-02 8-8-02 8-15-02 8-16-02 8-19-02 8-20-02 8-22-02 9-16-02 9-18-02						(I)(A)(10)(a)	service. Reimbursement per MFG is recommended. 11 X $43.00 = $473.00
8-6-02 8-16-02 8-19-02 9-16-02 9-18-02	97122	$45.00	$0.00	No EOB	$43.00	Medicine GR (I)(A)(9)(b) (I)(C)(9)	Documentation does not support one to one supervision per MFG. No reimbursement is recommended.
8-8-02 8-12-02 8-13-02 8-15-02 8-16-02 8-19-02 8-20-02 8-22-02	97110 (X2)	$90.00	$0.00	No EOB	$35.00 each 15 minutes	Medicine GR (I)(A)(9)(b) (I)(C)(9)	Documentation does not support one to one supervision per MFG. No reimbursement is recommended.
9-16-02 9-20-02	97110 (X3)	$135.00	$0.00	No EOB	$35.00 each 15 minutes	Medicine GR (I)(A)(9)(b) (I)(C)(9)	Documentation does not support one to one supervision per MFG. No reimbursement is recommended.
8-14-02	99212	$75.00	$0.00	No EOB	$32.00	E/M GR (VI)(B)	Documentation supports billed service. Reimbursement per MFG is recommended. 1 X $32.00 = $32.00
8-14-02	95900-27	$200.00	$0.00	No EOB	$64.00 each nerve x 70% for TC = $44.80	Medicine GR (IV)(D)	
8-14-02	95935-27	$608.90	$0.00	No EOB	$53.00 each extremity x 70% for TC = $37.10	Medicine GR (IV)(B)	
8-14-02	95904-27	$400.00	$0.00	No EOB	$64.00 each nerve x 70% for TC = $44.80	Medicine GR (IV)(D)	
8-14-02	95925-27 (x2)	$165.00 X 2 = $230.00	$0.00	No EOB	$175.00 each study X 70% = $122.50	Medicine GR (IV)(D) MFG Preamble	
8-21-02	99361	$53.00	$0.00	No			

				EOB			
8-23-02 9-20-02	99214 99214-25	$125.00	$0.00	No EOB	$71.00	E/M GR (VI)(B)	
8-23-02 9-20-02	97750	$75.00	$0.00	No EOB			
9-23-02	99455-RP	$50.00	$0.00	No EOB			
TOTAL							

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 to dates of service 7-30-02 through 9-6-02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 2nd day of July 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

April 25, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1335-01

___ 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 36 year-old male who was injured on when the rear tire of the truck he was driving blew out on ___. The patient's chief complaints have been constant moderate neck pain with paresthesia and numbness to bilateral upper extremities, constant moderate mid low back pain and intermittent moderate low back pain. EMG findings were reported to be consistent with bilateral lower cervical radiculopathy affecting the left C5 nerve root and the left and right posterior primary rami. He has been diagnosed with cervical radiculopathy, acute traumatic thoracic sprain/strain and acute traumatic lumbar sprain/strain. Treatment has included chiropractic treatment.

Requested Services
Office visits and physical therapy from 7/30/02 to 9/6/02.

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

Rationale/Basis for Decision
The ___ chiropractor reviewer noted that this case concerns a 36 year-old male who sustained work-related injuries to his neck and back on ___. The ___ chiropractor reviewer also noted that he has been diagnosed with cervical radiculopathy, acute traumatic thoracic sprain/strain and acute lumbar sprain/strain. The ___ chiropractor reviewer explained that the treatment the patient received from 7/30/02 to 9/6/02 was reasonable and medically necessary. (Mercy Guidelines. Croft, Cervical Acceleration/Deceleration Syndrome.)Therefore, the ___ chiropractor consultant concluded that the office visits and physical therapy from 7/30/02 to 9/6/02 were medically necessary to treat this patient's condition.

Sincerely,