MDR Tracking Number: M5-03-1404-01

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 2-6-03.

The IRO reviewed physical therapy, chiropractic manipulation, electric muscle stimulation, myofascial release, ultrasound, therapeutic exercise, traction and heat/ice application rendered from 4-29-02 through 5-21-02 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 records do not support ice therapy and ultrasound after three weeks, the office visits and other physical therapy services were medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees. 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.

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 with EOB denial "O" will be reviewed in accordance with *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
4-15-02 4-16-02	99213MP	$61.00	$0.00	O	$48.00	Medicine GR (I)(B)(1)(b)	SOAP note supports billed service per MFG, reimbursement of 2 dates X $48.00 = $96.00.
4-15-02 4-16-02	97010	$22.00	$0.00	O	$11.00	CPT Code Descriptor	SOAP note supports billed service per MFG, reimbursement of 2 dates X $11.00 = $22.00.
4-15-02	97014	$25.00	$0.00	O	$15.00	CPT Code Descriptor	SOAP note supports billed service per MFG, reimbursement of $15.00 is recommended.
4-16-02	97035	$30.00	$0.00	O	$22.00	CPT Code Descriptor	SOAP note supports billed service per MFG, reimbursement of $22.00 is recommended.
4-16-02	97032	$30.00	$0.00	O	$22.00	CPT Code Descriptor	SOAP note supports billed service per MFG, reimbursement of $22.00 is recommended.
5-6-02	99213MP	$61.00	$0.00	F	$48.00	Medicine GR (I)(B)(1)(b)	SOAP note supports billed service per MFG, reimbursement of $48.00 is recommended.
TOTAL							The requestor is entitled to reimbursement of **$225.00.**

This Decision is hereby issued this 12th 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 8-28-01 through 12-28-01 in this dispute.

This Order is hereby issued this 12th day of November 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

April 25, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1404-01

___ 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 female who sustained a work related injury on ___. The patient reported that while at work she fell causing injury to her neck and midback and referred pain to her shoulders. The patient was initially treated with oral pain medication.

The patient underwent X-Rays of the cervical and lumbar spine. The patient has been treated with chiropractic care that included physical medicine treatment, chiropractic manipulation, electric muscle stimulation, myofascial release, ultrasound and therapeutic exercise, traction and heat/ice application.

Requested Services
Office VisitsPhysical therapy on 4/29/02 through 5/21/02.

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 ___ chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her neck and back on ___. The ___ chiropractor reviewer also noted that the patient was treated with chiropractic care that included physical medicine treatment, chiropractic manipulation, electric muscle stimulation, myofascial release, ultrasound and therapeutic exercise, traction and heat/ice application. The ___ chiropractor reviewer explained that the available records do not support the use of ice therapy. The ___ chiropractor reviewer also explained that ultrasound should not be used after 3 weeks unless it is use is stopped for two weeks The ___ chiropractor reviewer also explained that the manipulations did offer relief to this patient.
Therefore, the ___ chiropractor consultant concluded that office visits and the other physical therapy services provided from 4/29/02 through 5/21/03 were medically necessary to treat this patient's condition.

Sincerely,