MDR Tracking Number: M5-03-1524-01

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 2-19-03.

The IRO reviewed chiropractic treatment rendered from 2-22-02 through 10-11-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. 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.

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.

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:

Neither party submitted EOBs to support services identified as "No EOB"; therefore, they will be reviewed in accordance with *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
8-26-02	99213	$48.00	$0.00	G	$48.00	Evaluation & Management GR (IV)	Office visit is not global to any service billed on this date; SOAP note supports level of service billed per MFG; therefore, reimbursement is recommended of $48.00.

8-26-02	97530	$35.00	$0.00	F	$35.00	CPT Code Descriptor	SOAP note supports service billed per MFG, reimbursement of $35.00 is recommended.
8-26-02	97112	$35.00	$0.00	F	$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	SOAP note does not support severity of injury to require exclusive one to one supervision per MFG, no reimbursement is recommended.
9-5-02	99080	$15.00	$0.00	N	$15.00	Rule 133.106 Rule 133.307(g)(3)(B)	TWCC-73 report was not submitted to support fee dispute, no reimbursement is recommended.
10-1-02 10-2-02 10-4-02	99213	$48.00	$0.00	No EOB	$48.00	Evaluation & Management GR (IV)	SOAP note supports level of service billed per MFG; therefore, reimbursement is recommended of $48.00 X 3 dates = $144.00.
10-1-02 10-4-02	97530	$35.00 $70.00	$0.00	No EOB	$35.00 / 15 min	CPT Code Descriptor	SOAP note supports service billed per MFG, reimbursement of $105.00 is recommended.
10-2-02	97250	$43.00	$0.00	No EOB	$43.00	CPT Code Descriptor	SOAP note supports service billed per MFG, reimbursement of $43.00 is recommended.
10-2-02 10-4-02	97265	$43.00	$0.00	No EOB	$43.00	CPT Code Descriptor	SOAP note supports service billed per MFG, reimbursement of $43.00 X 2 = $86.00 is recommended.
10-2-02 10-4-02	97035	$22.00	$0.00	No EOB	$22.00	CPT Code Descriptor	SOAP note supports service billed per MFG, reimbursement of $22.00 X 2 = $44.00 is recommended.
10-4-02	99080	$15.00	$0.00	No EOB	$15.00	Rule 133.106 Rule 133.307(g)(3)(B)	TWCC-73 report was not submitted to support fee dispute, no reimbursement is recommended.
TOTAL							The requestor is entitled to reimbursement of **$505.00.**

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 2-20-02 through 10-4-02 in this dispute

This Decision and Order is hereby issued this 4th day of December 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

April 28, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1524-01

___ 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 39 year-old female who injured her hip, thoracic spine, lumbar spine, cervical spine and right shoulder at work on ___. She started to receive treatment for her injuries from a chiropractor on 10/26/01. MRIs of her cervical, thoracic and lumbar spines were performed on 12/8/01. These MRIs revealed lordosis, a C3-4 1-2mm posterior central discal substance herniation, T7-8 and T8-9 drying or desiccation of disc substance only, and L4-5 symmetric annular disc bulge and drying or desiccation of disc substance. An orthopedic consultation in January 2002 resulted in diagnoses of torn right rotator cuff with clinical impingement, intervertebral disc disease or ght lumbar spine with myelopathy, lumbar degenerative disc disease involving L5-S1, degenerative disc disease of the cervical spine involving C5-6 with disc herniation and protrusion.

Lower extremity somatosensory testing performed on 1/23/02 reevealed prolonged right L3 dermatomal suggestive or a neurogenic process.

Requested Services
Joint mobilization, office visit, therapeutic activities & procedures, neuromuscular reeducation & stimulation, special reports, physician team conference, application of a surface neuro, copies, ultrasound, traction, electrical stimulation and myofascial release from 2/22/02 through 8/22/02 and from 8/27/02 through 10/11/02.

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

Rationale/Basis for Decision
The ___ chiropractor reviewer noted that this case concerns a 39 year-old female who sustained a work related injury to her back on ___. The ___ chiropractor reviewer also noted that the patient has been treated with conservative chiropractic care. The ___ chiropractor reviewer explained that the clinical documentation provided failed to support medical necessity of treatment rendered to this patient. The ___ chiropractor reviewer also explained that the documentation provided failed to show orthopedic or neurological testing results, documentation of how the patient felt office visit to office visit, a rating of the patient's pain or improvement in this patient's condition with the treatment rendered. The ___ chiropractor reviewer further explained that the documentation failed to show clear and specific motor, sensory and deep tendon reflexes along with specific orthopedic testing pertinent to the case. Therefore, the ___ chiropractor consultant concluded that the joint mobilization, office visit, therapeutic activities & procedures, neuromuscular reeducation & stimulation, special reports, physician team conference, application of a surface neuro, copies, ultrasound, traction, electrical stimulation and myofascial release from 2/22/02 through 8/22/02 and from 8/27/02 through 10/11/02 were not medically necessary to treat this patient's condition.

Sincerely,