MDR Tracking Number: M5-03-1705-01

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 3-11-03.

The IRO reviewed chiropractic treatment and physical therapy services rendered from 5-22-02 through 11-14-02 that were denied based upon "V".

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 May 13, 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
6-5-02 8-21-02 9-20-02 10-3-02	99213	$48.00	$0.00	No EOB	$48.00	Evaluation & Management GR (IV)	Office visit reports support billed service per MFG, reimbursement of 7

10-4-02 10-22-02 11-20-02							dates X $48.00 = $336.00.
9-20-02 10-3-02 10-4-02	97265	$43.00	$0.00	No EOB	$43.00	CPT Code Descriptor	SOAP notes support physical therapy service per MFG, reimbursement of 3 dates X $43.00 = $129.00.
9-20-02 10-3-02 10-4-02	97250	$43.00	$0.00	No EOB	$43.00		SOAP notes support physical therapy service per MFG, reimbursement of 3 dates X $43.00 = $129.00.
9-20-02 10-3-02 10-4-02	97122	$35.00	$0.00	No EOB	$35.00		SOAP notes support physical therapy service per MFG, reimbursement of 3 dates X $35.00 = $105.00.
9-20-02 10-3-02 10-4-02	97110 (4)	$140.00	$0.00	No EOB	$35.00 /15 min	Medicine GR (I)(A)(9)(b)	SOAP note does not support exclusive one to one supervision per MFG to support billing of 97110; therefore, no reimbursement is recommended.
TOTAL							The requestor is entitled to reimbursement of **$699.00.**

This Decision is hereby issued this 30th day of December 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 5-22-02 through 11-20-02 in this dispute.

This Order is hereby issued this 30th day of December 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

May 8, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1705-01

___ 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 48 year-old male who sustained a work related injury on ___. The patient reported that while at work, a 20-30 pound box fell on his head. The patient underwent X-Rays 2/6/02 of his cervical spine that showed no fracture.

The patient also underwent a CT of the cervical spine 2/6/02 that showed C5-6 disc herniation paracentral to the right with cord compression. An MRI on 2/6/02 showed focal disc herniation at the C5-6 level and moderated central canal stenosis at the C6-7 disc level. The patient underwent a cervical spine surgery and was treated postoperative with chiropractic care that included joint mobilization, myofascial release, traction and manipulations.

Requested Services
Office visit, therapeutic procedure, joint mobilization, myofascial release, traction, office visits with manipulations 5/22/02, 5/29/02,6/13/02-8/14/02, 8/28/02-9/16/02, 9/25/02-10/2/02, 10/9/02, 10/16/02, 10/28/02-11/14/02.

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 48 year-old male who sustained a work related injury to his cervical spine on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included C5-6 disc herniation paracentral to the right with cord compression and moderate central canal stenosis at the C6-7 disc level.

The ___ chiropractor reviewer further noted that the patient was treated with chiropractic care that included joint mobilization, myofascial release, traction and manipulations after cervical spine surgery. The ___ chiropractor reviewer explained that the treatment rendered to this patient was reasonable and medically necessary. Therefore, the ___ chiropractor consultant concluded that the office visit, therapeutic procedure, joint mobilization, myofascial release, traction, office visits with manipulations 5/22/02, 5/29/02, 6/13/02-8/14/02, 8/28/02-9/16/02, 9/25/02-10/2/02, 10/9/02, 10/16/02, 10/28/02-11/14/02 were medically necessary to treat this patient's condition.

Sincerely,