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

SOAH DOCKET NO. 453-04-3715.M5

MDR Tracking Number: M5-03-2649-01

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, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 6-19-03.

The IRO reviewed office visits, vasopneumatic device, myofascial release, joint mobilization, and therapeutic activities rendered on 7-11-02 through 9-5-02 and 10-16-02 through 12-6-02 that were denied as unnecessary medical.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the medical necessity issues. The IRO agreed with the carrier's decision that the electrical stimulation and therapeutic activities from 7-11-02 through 7-22-02 were **not** medically necessary. The IRO concluded that the office visits, vasopneumatic device, joint mobilization, and myofascial release from 7-11-02 through 9-5-02 and 10-16-02 through 12-6-02 were medically necessary. 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 12-10-03, 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:

DOS	CPT CODE	Billed $	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
6-27-02 6-28-02 7-3-02 7-10-02 7-17-02 9-11-02	99213 99214 99215 99215 99214 99215	$50.00 75.00 105.00 105.00 75.00 105.00	0.00	N	$48.00 71.00 103.00 103.00 71.00 103.00	96 MFG E/M GR VI B; Rule 133.307 (g) (3)	Carrier denied, as "N-documentation does not support the service billed." Code 99213 requires two of three key components

DOS	CPT CODE	Billed $	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
10-9-02	99215	105.00			103.00		– expanded problem focused history, expanded problem focused exam, and medical decision making of low complexity. Code 99214 requires two of three key components – detailed history, detailed exam, and medical decision making of moderate complexity. Code 99215 requires two of three key components – comprehensive history, comprehensive exam, and medical decision making of high complexity. Daily note submitted does not support level of service billed for 7-17-02. Relevant documentation for remaining dates of service were not submitted. No reimbursement recommended.
TOTAL		$650.00	0.00				The requestor is not entitled to reimbursement.

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 Order is applicable for dates of service 7-11-02 through 12-6-02 in this dispute.

This Order is hereby issued this 27th day of January 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

August 22, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-2649-01

___ 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 24 year-old male who sustained a work related injury on ___. The patient reported that while at work he was doing some heavy lifting when he began to experience low back pain. The patient was initially diagnosed with severe low back pain with spasms and bilateral lower extremity radiculitis. He was initially treated with medications, physical therapy and manipulations. The patient underwent an MRI and EMG testing. The patient was also evaluated by pain management and underwent SI joint injections.

Requested Services

Office visits, electrical stimulation, vasopneumatic device therapy, therapeutic activities, joint mobilization and myofascial release from 7/11/02 through 9/5/02, 10/16/02 through 12/6/02.
(Do not review CPT code 99214 for date of service 7/17/02).

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 24 year-old male who sustained a work related injury to his low back on ___. The ___ chiropractor reviewer also noted that the

diagnoses for this patient included severe low back pain with spasms and bilateral lower extremity radiculitis. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included medications, physical therapy, manipulations and SI injections. The ___ chiropractor reviewer indicated that the treatment this patient received was reasonably related to his injury and medically necessary. The ___ chiropractor reviewer explained that the patient was doing very well but then suffered some exacerbations. The ___ chiropractor reviewer indicated that the exacerbations would warrant some follow up care. The ___ chiropractor reviewer explained that the patient was referred out for injections after there appeared to be no complete resolution with the treatment rendered. The ___ chiropractor reviewer also explained that the injections seemed to eliminate the rest of this patient's pain. The ___ chiropractor reviewer further explained that the treatment rendered to this patient followed the accepted standards of care. However, the ___ chiropractor reviewer indicated that there was some duplication of services. The ___ chiropractor reviewer explained that these services were not adequately documented and therefore are denied. Therefore, the ___ chiropractor consultant concluded that the electrical stimulation and therapeutic activities from 7/11/02 through 7/22/02 were not medically necessary to treat this patient's condition. However, the ___ chiropractor consultant concluded that the office visits, vasopneumatic device therapy, joint mobilization and myofascial release from 7/11/02 through 9/5/02 and from 10/16/02 through 12/6/02 were medically necessary to treat this patient's condition.

Sincerely,