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

SOAH DOCKET NO. 453-04-4339.M5

MDR Tracking Number: M5-03-2688-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 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 6-23-03.

The IRO reviewed office visits w/manipulations, joint mobilization, electrical stimulation, myofascial release, and therapeutic exercises rendered from 10-28-02 through 12-19-02 and 12-27-02 that were denied as not 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-6-03, 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$ (Maximum Allowable Reimbursement)	Reference	Rationale
9-20-02 9-24-02	99080	$50.00x2	0.00	F	$15.00	Rule 129.5; Rule 133.106(b) and Rule 133.307(g)(3)	Relevant documentation does not support delivery of service. No reimbursement recommended.

DOS	CPT CODE	Billed$	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12/26/02	97750 -26 3 hrs	$150.00	0.00	N	$43.00 ea 15 min -26 modifier reimbursed at 30% of MAR	96 MFG Med GR I E; CPT descriptor, Rule 133.307 (g)(3)	Test report dated 12-26-02 supports delivery of service. Recommend reimbursement of $129.00 x 30% = $103.20.
12/30/02	99213 - MP 97265 97250 97110 97014	$48.00 $43.00 $43.00 $35.00 $15.00	0.00	D	$48.00 $43.00 $43.00 $35.00 ea 15 min $15.00	96 MFG Med GR I A 10 a; I B 1 b; Rule 133.307 (g)(3)	Relevant documentation was not submitted for this date of service; therefore no reimbursement can be recommended.
1-6-03 Thru 1-29-03	99213 - MP 97265 97250 97110 97014	$48.00 x 12 $43.00 x 12 $43.00 x 12 $35.00 x 12 $15.00 x 12	0.00	No EOB	$48.00 $43.00 $43.00 $35.00 ea 15 min $15.00	96 MFG Med GR I A 10 a; I B 1 b; Rule 133.307 (g)(3)	Relevant documentation does not support level of service in that manipulations are not documented. Also, all other physical therapy modalities are not documented. Therefore no reimbursement can be recommended.
TOTAL	$2,642.00	0.00	The requestor is entitled to reimbursement of $103.20.				

The above Decision is hereby issued this 27th day of January 2004.

Dee Z. Torres
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 10-28-02 through 12-27-02 in this dispute.

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

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dzt

September 16, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-2688-01

___ 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 reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. 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 male who sustained a work related injury on ___. The patient reported that while at work he was drilling holes into thick sheet metal when the bit became lodged in the metal. The patient reported that drill began spinning in his hand, twisting his right hand and wrist. The diagnoses for this patient included fracture of the 4th metacarpal of the right hand and a grade II sprain/strain to the right wrist. The patient was place in a cast for three weeks. The patient was also treated with passive care, manipulative treatments and active rehabilitation. The patient also participated in a work hardening program.

Requested Services
Office visits with manipulations, joint mobilization, electrical stimulation, myofascial release, therapeutic exercises from 10/28/02 through 12/19/02 and 12/27/02.

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 male who sustained a work related injury to his right hand and wrist. The ___ Chiropractor reviewer also noted that the diagnoses for this patient included fracture of the 4th metacarpal of the right hand and a grade II sprain/strain to the right wrist. The ___ chiropractor reviewer indicated that the patient presented with significant pain and a well documented grade II sprain/strain and resolving fracture of the 4th metacarpal. The ___ chiropractor reviewer explained that the patient underwent an appropriate course of care that showed steady improvement of his condition and ultimate return to work without restrictions or pain. Therefore, the ___ chiropractor consultant concluded that the office visits with manipulations, joint mobilization, electrical stimulation, myofascial release, therapeutic exercises from 10/28/02 through 12/19/02 and 12/27/02 were medically necessary to treat this patient's condition at this time.

Sincerely,