

MDR Tracking Number: M5-03-3068-01

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 7-25-03.

The IRO reviewed office visits, therapeutic procedure, physical medicine treatment, range of motion testing, physical performance test, kinetic activities, and manipulations from 1-8-03 through 2-12-03 and 2-19-03 through 3-13-03 that were denied as unnecessary medical.

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.

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 9-30-03, 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
2-17-02	99214	85.00	0.00	D	71.00	96 MFG E/M GR VI B	Progress Evaluation Note supports delivery of service. Recommend reimbursement of \$71.00
TOTAL		85.00	0.00				The requestor is entitled to reimbursement of \$71.00.

**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 6-3-02 through 10-9-02 in this dispute.

This Order is hereby issued this 23rd day of January 2004.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

September 23, 2003

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-03-3068-01**

\_\_\_ 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 hit on the right side of his head by the hood of his bus. The patient was initially evaluated with X-Rays and was diagnosed with a concussion and cervical sprain. The patient was treated with about 1 week of physical therapy and was then treated with chiropractic care that began on 12/3/02. The patient underwent a cervical MRI that showed C4-C5 and C5-C6 protrusions. Diagnoses for this patient have included cervical sprain/strain, cervical disc protrusion, cervicgia, cervical spine muscle spasm and right TMJ dysfunction. Treatment of this patient's condition has also included EMS, oral medications, and spinal manipulations.

### Requested Services

Office visits, therapeutic procedure, physical medicine treatment, range of motion testing, physical performance test, kinetic activities, manipulations from 1/8/03 through 2/12/03 and from 2/19/03 through 3/13/03.

### 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 head and cervical spine on \_\_\_. The \_\_\_ chiropractor reviewer also noted that the diagnoses for this patient included cervical sprain/strain, cervical disc protrusion, cervicgia, cervical spine muscle spasm and right TMJ dysfunction. The \_\_\_ chiropractor reviewer further noted that the treatment for this patient's condition has included physical therapy, chiropractic care, EMS, oral medications and spinal manipulations. The \_\_\_ chiropractor reviewer indicated that the treatment for this patient was short term. The \_\_\_ chiropractor reviewer explained that the patient's response to treatment was good. Therefore, the \_\_\_ chiropractor consultant concluded that the office visits, therapeutic procedure, physical medicine treatment, range of motion testing, physical performance test, kinetic activities, manipulations from 1/8/03 through 2/12/03, and from 2/19/03 through 3/13/03 were medically necessary to treat this patient's condition.

Sincerely,