MDR Tracking Number: M5-03-3072-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 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 July 25, 2003.

The IRO reviewed office visits, myofascial release, ultrasound therapy, electrical stimulation, hot/cold packs and therapeutic exercises rendered from 8/20/02 through 1/17/03 denied based upon "U".

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.

The office visits; myofascial release, ultrasound therapy, electrical stimulation, hot/cold packs and therapeutic exercises rendered from 8/20/02 through 10/18/02 were found to be medically necessary.

The office visits; myofascial release, ultrasound therapy, electrical stimulation, hot/cold packs and therapeutic exercises rendered from 10/19/02 through 1/17/03 were not found to be medically necessary.

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 October 21, 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:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
7/26/02	A4556 Electrodes	$50.00	$0.00	G	DOP	HCPCS descriptor	The carrier did not submit to the commission relevant information to support (previous charges) their denial of "G". The electrodes are not global to the TWCC-73 report. Reimbursement in the amount of $50.00.
	99080-73	$20.00	$0.00	F	$15.00	Rule 129.5	Review of the TWCC-73

							supports delivery of service. Reimbursement is recommended in the amount of $15.00.
8/8/02	99205	$210.00	$0.00	N/F	$137.00	MFG, Evaluation/ Management Ground Rule (VI)(A)	Review of the office note meets the documentation criteria set forth by the Medical Fee Guideline. Therefore, the requestor is entitled to reimbursement in the amount of $137.00.
8/16/02	99080-73	$20.00	$0.00	F	$15.00	Rule 133.307 (g)(3) Rule 129.5	The requestor did not submit relevant information to support delivery of service. Reimbursement is therefore not recommended.
10/1/02	99214	$77.00	$0.00	N	$71.00	MFG, Evaluation/ Management Ground Rule (VI)(B)	Review of the office note meets the documentation criteria set forth by the MFG. Reimbursement is recommended in the amount of $71.00.
	99080-73	$20.00	$0.00	F	$15.00	Rule 129.5	Review of the TWCC-73 supports delivery of service. Reimbursement is recommended in the amount of $15.00.
10/4/02	99204	$140.00	$0.00	F	$106.00	MFG, Evaluation/ Management Ground Rule (VI)(A)	Review of the office note supports delivery of service. Reimbursement is recommended in the amount of $106.00.
10/25/02	97010	$15.00	$0.00	F	$11.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii), (I)(A)(10)(a)	Review of the Daily Treatment Log supports delivery of service. Reimbursement is recommended in the amount of $11.00.
	97110	$120.00	$0.00	F	$105.00	MFG, Medicine Ground Rule (I)(A)(9)(b), (I)(A)(10)(a) & (I)(A)(11)(a) Section 413.016	The MRD declines to order payment because the daily notes did not indicate whether the doctor was conducting exclusive one-to-one sessions with the claimant and did not clearly indicate the exclusive need for one-on-one supervision. In addition there was no statement of the claimant's medical condition or symptoms that would

							mandate one-on-one supervision for an entire session or over an entire course of treatment. Therefore reimbursement is not recommended.
11/1/02	99214	$77.00	$0.00	N	$71.00	MFG, Evaluation/ Management Ground Rule (VI)(B)	Review of the office note meets the documentation criteria set forth by the MFG. Reimbursement is recommended in the amount of $71.00.
	99080-73	$20.00	$0.00	F	$15.00	Rule 129.5	Review of the TWCC-73 supports delivery of service. Reimbursement is recommended in the amount of $15.00.
11/15/02	90855	$180.00	$153.00	C	$3.00/min	CPT code descriptor	Both the requestor and respondent failed to submit relevant information to support and/or challenge the carrier's denial of "C". Therefore, it could not be determined in a contract exists. Reimbursement is not recommended.
	90900	$300.00	$0.00	F/C	$2.00/min	CPT code descriptor	
11/22/02	90900	$300.00	$0.00	F/C	$2.00/min	CPT code descriptor	
	90855	$150.00	$0.00	C	$3.00/min	CPT code descriptor	
12/2/02	99214	$77.00	$0.00	N	$71.00	MFG, Evaluation/ Management Ground Rule (VI)(B)	Review of the office note meets the documentation criteria set forth by the MFG. Reimbursement is recommended in the amount of $71.00.
	99080-73	$20.00	$0.00	F	$15.00	Rule 129.5	Review of the TWCC-73 supports delivery of service. Reimbursement is recommended in the amount of $15.00.
12/17/02	99080-73	$20.00	$0.00	F	$15.00	Rule 129.5	Review of the TWCC-73 supports delivery of service. Reimbursement is recommended in the amount of $15.00.
	90855	$180.00	$153.00	C	$3.00/min	CPT code descriptor	The requestor and respondent failed to submit relevant information to support and/or challenge the carrier's denial of "C". Therefore, it could not be determined if a

							contract exists between the requestor and respondent. Reimbursement is not recommended.
1/17/03	99080-73	$20.00	$0.00	F/U	$15.00	Rule 129.5	Review of the TWCC-73 supports delivery of service. Reimbursement is recommended in the amount of $15.00.
1/27/03	90900	$300.00	$0.00	A	$2.00/min	CPT code descriptor	Review of the preauthorization letter from Texas Mutual Insurance Company, dated 11/1/02 supports that preauthorization was obtained for Biofeedback 10 sessions. Reimbursement is recommended in the amount of $300.00.
2/5/03	99213	$60.00	$0.00	F	$48.00	MFG, Evaluation/ Management Ground Rule (VI)(B)	The requestor did not submit relevant information to support delivery of service. Reimbursement is therefore not recommended.
	99080-73	$20.00	$0.00	F	$15.00	Rule 129.5	
2/12/03	99372	$35.00	$0.00	N	$21.00	MFG, Evaluation/ Management Ground Rule (XVIII)(C)	Review of the office note dated 2/12/03, does not meet the documentation criteria set forth by the MFG. Reimbursement is not recommended.
2/17/03	90900	$300.00	$0.00	A	$2.00/min	CPT code descriptor	Review of the preauthorization letter from ___, dated 11/1/02 supports that preauthorization was obtained for Biofeedback 10 sessions. Reimbursement is recommended in the amount of $300.00.
2/24/03	90900	$300.00	$0.00	A	$2.00/min	CPT code descriptor	Review of the preauthorization letter from ___, dated 11/1/02 supports that preauthorization was obtained for Biofeedback 10 sessions. Reimbursement is recommended in the amount of $300.00.
2/27/03	99213	$60.00	$0.00	F/C	$48.00	MFG, Evaluation/ Management	The requestor and respondent failed to submit relevant information to support and/or

						Ground Rule (VI)(B)	challenge the carrier's denial of "C". Therefore, it could not be determined if a contract exists between the requestor and respondent. Reimbursement is not recommended.
TOTAL		$3001.00	$0.00		$2819.00		The requestor is entitled to reimbursement in the amount of $1,507.00

This Decision is hereby issued this 13th day of February 2004.

Margaret Q. Ojeda
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 7/26/02 through 2/27/03 in this dispute.

This Order is hereby issued this 13th day of February 2004.

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

October 1, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-3072-01

___ 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 43 year-old female who sustained a work related injury on ___. The patient reported that while at work she was moving some boxes when she felt a "pop" in her low back. The patient underwent lumbosacral X-Rays and an MRI of the lumbar spine and coccyx. The patient has also undergone an EMG/NCV, psychological evaluation and biofeedback and pain management evaluation. The patient has been treated with chiropractic care that included ultrasound therapy, myofascial release, electrical stimulation and therapeutic exercises and has also undergone trigger point injections. The diagnoses for this patient have included mechanical lumbar back pain without radiculopathy.

Requested Services
Office visits, myofascial release, ultrasound therapy, electric stimulation therapy, hot or cold packs and therapeutic exercises from 8/20/02 through 1/17/03.

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 43 year-old female who sustained a work related injury to her low back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included mechanical lumbar back pain without radiculopathy. The ___ chiropractor reviewer further noted that the treatment for this patient has included ultrasound therapy, myofascial release, electrical stimulation, therapeutic exercises and trigger point injections. The ___ chiropractor reviewer indicated that the patient had an uncomplicated lumbar mechanical dysfunction that did not respond to conservative care or any care that was given. The ___ chiropractor reviewer explained that 12 weeks of care from the initial start date of 7/26/02 is medically necessary and reasonable. The ___ physician reviewer also explained that if the patient is not showing improvement within the 12-week time frame, care should be discontinued and other forms of care should be instituted. The ___ chiropractor reviewer noted that although other types of care were started, the chiropractic treatment continued. The ___ chiropractor reviewer explained that the documentation provided did not demonstrate that the patient was improving with the chiropractic treatment. The ___ chiropractor reviewer explained that the patient reported the most improvement with medications and injections. The ___ chiropractor reviewer also explained that the patient failed to show a positive response to care. Therefore, the ___ chiropractor consultant concluded that the office visits, myofascial release, ultrasound therapy, electric stimulation therapy, hot or cold packs and therapeutic exercises from 8/20/02 through 10/18/02 were medically necessary to treat this patient's condition. However, the ___ chiropractor consultant also concluded that the office visits, myofascial release, ultrasound therapy, electric stimulation therapy, hot or cold packs and therapeutic exercises from 10/19/02 through 1/17/03 were not medically necessary to treat this patient's condition.

Sincerely,