MDR Tracking Number: M5-03-3074-01

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; office visits w/manipulations, mechanical traction, therapeutic activities and exercises from 12-3-02 through 5-5-03.

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 concluded that the office visits, office visits w/manipulations, and therapeutic activities and exercises **were** medically necessary. The IRO agreed with the previous determination that the mechanical traction **was not** 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 10-21-03, 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
1/27/03	99213 97110 (1) 97265	$65.00 $50.00 $45.00	$0.00	No EOB	$48.00 $35.00 ea 15 min $43.00	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service for office visit only. Recommend reimbursement of $48.00.
3/14/03	99213	$65.00	$0.00	No EOB	$48.00		Relevant information supports delivery of service. Recommend reimbursement of $48.00

3/26/03	99213	$65.00	$0.00	R	$48.00		Carrier filed a TWCC-21 disputing vitreous degeneration; however requestor did not treat this condition per the bill. Therefore this review will be per the 96 MFG. Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.
TOTAL		$290.00	$0.00				The requestor is entitled to reimbursement of $96.00.

This Decision is hereby issued this 22nd day of March 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 Order is applicable for dates of service 12-3-02 through 5-5-03 in this dispute.

This Order is hereby issued this 22nd day of March 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION **Amended Letter**
Note: Decision

September 25, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-3074-01
IRO Certificate #: IRO4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This patient was driving the company vehicle on ___ when he collided with another vehicle going through a traffic light. He reported neck pain with headache and right arm and hand numbness. He also reports visual disturbances. The patient saw a chiropractor for physical therapy and treatment.

Requested Service(s)
Office visits with manipulation, mechanical traction, therapeutic activities and exercises, and office visits from 12/03/02 through 01/20/03, 01/29/03 through 02/19/03, and 05/05/03

Decision
It is determined that the office visits with manipulation, therapeutic activities and exercises, and office visits from 12/03/02 through 01/20/03, 01/29/03 through 02/19/03, and 05/05/03 were medically necessary to treat this patient's condition. However, it is determined that the mechanical traction was not medically necessary to treat this patient's condition.

Rationale/Basis for Decision
The patient was started on an intensive conservative treatment plan initially. He began passive therapy and progressed to active therapy. Throughout the course of treatment, there were documented incidents of re-aggravation of his injuries that required additional care. Functional capacity testing and comparative muscle testing were performed that documented his injuries and revealed improvement over the course of his treatment.
National treatment guidelines allow for passive therapy with the progression into active therapy. Such is the situation in this case. Each date of service was significantly documented to warrant treatment of his on the job injury. However, there are no treatment guidelines that allow for medical necessity of mechanical traction to be utilized four months after the date of injury. Therefore, it is determined that the office visits with manipulation, therapeutic activities and exercises, and office visits from 12/03/02 through 01/20/03, 01/29/03 through 02/19/03, and 05/05/03 were medically necessary. However, it is determined that the mechanical traction was not medically necessary.

Sincerely,