MDR Tracking Number: M5-03-3143-01

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. The dispute was received on August 1,2003.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for office visits and work hardening. 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 October 13, 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$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
12/11/02	99213	48.00	0.00	F	48.00	MFG, E/M GR (IV)(C)(2)	Soap Notes were not submitted for dates of services to confirm delivery of services. No reimbursement recommended
12/12/03	99213	48.00	0.00	F			
12/17/03	99213	48.00	0.00	F	48.00	MFG, E/M GR (IV)(C)(2)	SOAP Notes support delivery of service as billed. Recommended reimbursement $48.00
12/17/03	97545 97546	128.00 384.00	307.00 0.00	F F	$64/ per hour $128 $64/ per hour $384 Total $512.00	MFG, MRG (II)(E)(4)	SOAP notes support delivery of services as billed. Additional reimbursement recommended $205.00
TOTAL		$656.00					The requestor is entitled to reimbursement of **$** 253.00

This Order is hereby issued this 5th day of January 2004.

Georgina Rodriguez
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 11-19-02 through 02-21-03 in this dispute.

This Order is hereby issued this 5th day of January 2004.

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

September 24, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-3143-01

___ 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 30 year-old male who sustained a work related injury on ___. The patient reported that while at work he was in a ditch that collapsed. The patient reported that large amounts of dirt struck

him in the head and lumbar area. The patient underwent an MRI of the cervical and lumbar spine on 8/20/02. The diagnoses for this patient included lumbar sprain/strain and spondylosis lumbar spine. The patient has been treated conservatively with pain medications, muscle relaxing medication, physical therapy and rehabilitation. The patient has also undergone an electrodiagnostic study on 9/22/02. The patient was further treated with a work hardening program.

Requested Services

Work Hardening program and office visits from 11/19/02 through 12/12/02, 12/24/02 and 2/21/03.

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 30 year-old male who sustained a work related injury to his head and lumbar back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included lumbar sprain/strain and spondylosis lumbar spine. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included pain medications, muscle relaxants, physical therapy and rehabilitation. The ___ chiropractor reviewer explained that the patient's response to treatment was slow. The ___ chiropractor reviewer also explained that given the extent of the patient's injury it would be expected that response to treatment would be slow. However, the ___ chiropractor reviewer further explained that the patient did respond to the treatment rendered. Therefore, the ___ chiropractor consultant concluded that the work hardening program and office visits from 11/19/02 through 12/12/02 and 12/24/02 and 2/21/03 were medically necessary to treat this patient's condition.

Sincerely,