MDR Tracking Number: M5-03-3378-01

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 7-24-03.

The IRO reviewed office visits w/manipulations, electrical stimulation, ultrasound, and myofascial release rendered from 7-24-02 through 7-31-02 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. The disputed dates of service 7-2-02 through 7-18-02 are untimely and not reviewable per TWCC Rule 133.307 (d)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute. The Commission received the medical dispute on 7-24-03.

On 11-17-03, 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**
7-29-02	99213 97035 97014 97250	$68.00 31.00 21.00 61.00	0.00	No EOB	$48.00 22.00 15.00 43.00	96 MFG Med GR I A 10 A; E/M GR VI B; Rule 133.307 (g)(3)	Daily note supports delivery of service for electrical stimulation and ultrasound only. Relevant documentation was not submitted to support office visit and myofascial release. Recommend reimbursement of $15.00 + $22.00 = $37.00.
TOTAL		$181.00	0.00				The requestor is entitled to reimbursement of $37.00

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 7-24-02 through 7-31-02 in this dispute.

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

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

November 13, 2003

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: ___
MDR Tracking #: M5-03-3378-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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. TMF'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 TMF 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 injured on the job on ___, mechanism unknown. She saw a chiropractor and was referred to an orthopedic surgeon who diagnosed her with post-traumatic internal disc derangement lumbar spine with herniation at L4-5 and L5-S1. The patient then saw a pain management specialist and underwent a lumbar epidural steroid injection series followed by physical therapy by the chiropractor.

Requested Service(s)

Electrical stimulation, ultrasound, myofascial release, and office visits with manipulation from 07/24/02 through 07/31/02

Decision

It is determined that the electrical stimulation, ultrasound, myofascial release, and office visits with manipulation from 07/24/02 through 07/31/02 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

National treatment guidelines allow for passive and active therapy in injuries of this nature. Normally, passive care is limited to an initial two to six weeks of treatment. It is usually agreed that active care in conjunction with epidural steroid injections (ESI) produce better overall results.

The records supply sufficient documentation on each visit to warrant the treatment she received. This case is an exception in that, due to the patient's condition, passive therapeutic modalities and office visits were in fact needed during the period of time between her ESIs and were in fact medically necessary for the treatment of her on the job injury. Therefore, it is determined that the electrical stimulation, ultrasound, myofascial release, and office visits with manipulation from 07/24/02 through 07/31/02 were medically necessary.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn