MDR Tracking Number: M5-03-3404-01

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 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 August 28, 2003.

The IRO reviewed office visit, special reports, and modalities rendered on 8/28/02 through 1/31/03 denied based upon "V".

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 November 5, 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
8/28/02	E0745-NU	$499.00	$0.00	L	DOP	MFG, General Instructions Ground Rule (III) HCPCs code descriptor	Review of the TWCC-53 revealed that the commission approved the TWCC-53 (Change of Treating Doctor Request) on 8/21/02 from ___ to___. Review of the a referral dated 8/28/02 revealed that ___ referred the injured worker within the same group to ___ for both treatment and evaluation. Therefore, the requestor is
8/28/02	L0515	$80.00	$0.00	L	DOP		
8/28/02	E0230	$40.00	$0.00	L	DOP		
8/29/02	99213	$60.00	$0.00	L	$48.00	MFG, Evaluation/ Management Ground Rule (I)(B) & (VI)(B)	
8/29/02	97250	$44.00	$0.00	L	$43.00	MFG, Medicine Ground Rule (I)(C)(3)	

8/29/02	97035	$26.00	$0.00	L	$22.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(iii), (I)(A)(10)(a-b)	entitled to reimbursement in the amount of $732.00. Review of the TWCC-53 revealed that the commission approved the TWCC-53 (Change of Treating Doctor Request) on 8/21/02 from ___ to ___ view of the a referral dated 8/28/02 revealed that ___ referred the injured worker within the same group to ___ for both treatment and evaluation. Therefore, the requestor is entitled to reimbursement in the amount of $443.00.
8/29/02	97014	$18.00	$0.00	L	$15.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii), (I)(A)(10)(a-b)	
8/29/02	97010	$15.00	$0.00	L	$11.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii), (I)(A)(10)(a-b)	
9/4/02	99213-MP	$60.00	$0.00	L	$48.00	MFG, Medicine Ground Rule (I)(B)(1)(b)	
9/4/02	97250	$44.00	$0.00	L	$43.00	MFG, Medicine Ground Rule (I)(C)(3)	
9/4/02	97035	$26.00	$0.00	L	$22.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(iii), (I)(A)(10)(a-b)	
9/4/02	97014	$18.00	$0.00	L	$15.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii), (I)(A)(10)(a-b)	
9/4/02	97010	$15.00	$0.00	L	$11.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii), (I)(A)(10)(a-b)	
9/6/02	99213-MP	$60.00	$0.00	L	$48.00	MFG, Medicine Ground Rule (I)(B)(1)(b)	
9/6/02	97250	$44.00	$0.00	L	$43.00	MFG, Medicine Ground Rule (I)(C)(3)	
9/6/02	97035	$26.00	$0.00	L	$22.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(iii), (I)(A)(10)(a-b)	
9/6/02	97014	$18.00	$0.00	L	$15.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii), (I)(A)(10)(a-b)	
9/6/02	97010	$15.00	$0.00	L	$11.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii), (I)(A)(10)(a-b)	

9/12/02	99213	$60.00	$0.00	L	$48.00	MFG, Evaluation/ Management Ground Rule (I)(B) & (VI)(B)	
9/12/02	97250	$44.00	$0.00	L	$43.00	MFG, Medicine Ground Rule (I)(C)(3)	
9/12/02	97035	$26.00	$0.00	L	$22.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(iii), (I)(A)(10)(a-b)	
9/12/02	97014	$18.00	$0.00	L	$15.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii), (I)(A)(10)(a-b)	
9/12/02	97010	$15.00	$0.00	L	$11.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii), (I)(A)(10)(a-b)	
TOTAL		$1,281.00	$0.00		$556.00		The requestor is entitled to reimbursement in the amount of $1,175.00

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

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

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 8/28/02 through 1/31/03 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

November 3, 2003

Re: MDR #: M5-03-3404-01
IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review,___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:
This female claimant was injured on her job on ___ when she bent over and felt and heard her back pop. The onset of pain was immediate from this injury. She was initially taken by ambulance for evaluation. Attempt at treatment was made with minimal results. The records indicate the patient was prescribed a few session of physical therapy, but made no progress. A lumbar MRI was ordered.

She changed doctors on 08/28/02. An initial evaluation was performed, and an aggressive treatment program was begun. Over the course of treatment, additional referrals and diagnostic testing in the form of electrodiagnostic studies, as well as FCEs, were performed. The lumbar MRI and lower extremity electrodiagnostic studies were interpreted as essentially normal. An initial trial of care was performed that resulted in sufficient positive improvement to warrant continued care.

The patient's condition improved to the point where she was able to progress from passive to active care. The records indicate the recommendation of possible S-I injections. However, the records do not indicate that the injections were performed. Apparently, the Designated Doctor placed the patient at MMI on 10/29/02.

Disputed Services:
Office visits, special reports, and modalities during the period of 08/28/02 through 01/31/03.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the office visits, reports and treatments in question were medically necessary in this case.

Rationale:
The patient was place at MMI only two months after initiation of treatment by the second treating physician. This appears to have been premature in that the patient had apparently not received adequate care in the initial two months immediately following her injury. This was even done prior to the patient's progressing into an active rehabilitative program.

National Treatment Guidelines allow for an initial trial of care of passive therapy with progression into active therapy. Normally, passive therapy guidelines allow for two to four weeks of care. However, due to the nature and extent of this patient's injury, and the delay in aggressive care, an

extended time of up to eight weeks of passive care would be reasonable. After the initial passive therapy, it is reasonable, and according to nationally accepted guidelines, for the patient to have an initial trial of active care. This was done, and the records do indicate this treatment was beneficial to the patient.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,