

THIS DECISION HAS BEEN APPEALED. THE
 FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
 SOAH DOCKET NO. 453-04-6070.M5

MDR Tracking Number: M5-04-0413-01

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 10-09-03.

The IRO reviewed therapeutic exercises, ROM measurements, office/outpatient visits, joint mobilization, myofascial release and manual therapy rendered from 04-24-03 through 06-05-03 that was 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.

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 12-23-03, 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\$	Reference	Rationale
5/8/03	95851	\$72.00 (1 unit @ \$36.00 X 2 units)	\$0.00	NO EOB	\$36.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$36.00 X 2 = \$72.00
5/21/03	99214	\$71.00	\$0.00	N	\$71.00	96 MFG E/M GR(VI)(B)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$71.00

TOTAL		\$143.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$143.00
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This Decision is hereby issued this 16th day of April 2004.

Debra L. Hewitt
 Medical Dispute Resolution Officer
 Medical Review Division
 DLH/dlh

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 04-24-03 through 06-05-03 in this dispute.

This Order is hereby issued this 16th day of April 2004.

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

NOTICE OF INDEPENDENT REVIEW DECISION

December 18, 2003

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

RE: MDR Tracking #: M5-04-0413-01
 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 sustained an injury on ___ while trying to break his fall from 40 feet. He grabbed a side rod with his right arm. He later reported back and right shoulder pain. He went to see a chiropractor for treatment and therapy.

Requested Service(s)

Therapeutic exercises, range of motion (ROM) measurements, office/outpatient visits, joint mobilization, myofascial release, and manual traction therapy from 04/24/03 through 06/05/03

Decision

It is determined that the therapeutic exercises, ROM measurements, office/outpatient visits, joint mobilization, myofascial release, and manual traction therapy from 04/24/03 through 06/05/03 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The initial visit to the chiropractor determined that the patient had a disorder of the tendons and bursae of the right shoulder. Physical therapies were started to restore function to the region. MRI of the lumbar spine performed on 05/22/03 revealed a disc bulge at T12-L1 and at L4-5 with the thecal sac mildly effaced. An electromyography study from 07/01/03 was consistent with L5 and S1 radiculopathy bilaterally. There was no medical evidence found in the documentation reviewed to support the idea that the provider's services were not medically necessary to treat this patient's injuries. The mechanism of injury described could definitely create problems to the shoulder girdle and the lumbar spine.

The documentation supports a multi-level discal injury with two levels minimally effacing the thecal sac; therefore, this injury cannot be classified in a sprain/strain algorithm. Among rehabilitation professionals, a discal injury warrants a controlled trial of physiotherapeutic application designed to restore function. It is clear from the documentation provided for this review that the provider applied physiotherapeutic applications in a controlled trial with appropriate periodic testing to determine the efficacy of therapy. Therefore, it is determined that the therapeutic exercises, range of motion (ROM) measurements, office/outpatient visits, joint mobilization, myofascial release, and manual traction therapy from 04/24/03 through 06/05/03 were medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- Jacob T, Zeev A, Epstein L. *Low back pain—a community-based study of care-seeking and therapeutic effectiveness*. Disabil Rehabil. 2003 Jan 21;(2): 67-76.
- *Unremitting low back pain. In: North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialists*. North American Spine Society (NASS); 2000. 96p.

Sincerely,