

MDR Tracking Number: M5-04-0553-01

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 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 10-23-03.

Dates of service prior to 10-23-02 were submitted untimely per above referenced rule and will not be considered in this decision.

The IRO reviewed office visits with manipulation, myofascial release, electric stimulation, ultrasound therapy, hot/cold pack therapy, prolonged evaluation and management rendered from 10-25-02 through 04-22-03 that were 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On December 29, 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
2-28-03 3-4-03 4-24-03 4-29-03	99213MP	\$48.00	\$0.00	N, F	\$48.00	CPT Code description Medicine GR (I)(B)(1)(b)	Documentation supports billed service per MFG. Reimbursement is recommended of \$48.00 X4 = \$192.00.

2-28-03 3-4-03 4-24-03 4-29-03	97250	\$43.00	\$0.00	N, F	\$43.00	CPT Code description	Documentation supports billed service per MFG. Reimbursement is recommended of \$43.00 X 4 = \$172.00.
4-30-03	99080-73	\$15.00	\$12.00	N, F	\$15.00	Rule 129.5(d) CPT Code description	A report to support service billed was not submitted. Additional reimbursement is not recommended.
TOTAL							The requestor is entitled to reimbursement of <b>\$364.00</b> .

This Decision is hereby issued this 7<sup>th</sup> day of September 2004.

Elizabeth Pickle  
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 10-25-02 through 04-30-03 in this dispute.

This Order is hereby issued this 7<sup>th</sup> day of September 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

January 2, 2003

**AMENDED NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-04-0553-01  
IRO Certificate #: 5348**

\_\_\_ 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 female who sustained a work-related injury on \_\_\_. The patient reported that while at work she injured her back. Diagnostic testing for this patient has included X-Rays of the lumbar spine on 6/20/02, MRI of the thoracic spine on 7/23/02, X-Rays of the thoracic spine on 8/27/02 and again on 1/2/03, fluoroscopic examination on 8/27/02, 1/2/03 and 1/28/03, spinal sonography on 2/12/03, ultrasound 2/12/03 and a EMG/NCV testing on 3/17/03. Diagnoses for this patient has included thoracic sprain/strain and thoracic spine facet disorder. Treatment for this patient has included physical therapy, pain management, and oral medications. The patient has also been treated with a TENS unit, neuromuscular stimulator and an ice cap collar. Further treatment for this patient has included spinal thoracic facet block and a right T5-T8 radiofrequency neurotomy.

### Requested Services

Office visit with manipulation, myofascial release, electric stimulation, ultrasound therapy, hot/cold pack therapy, prolonged evaluation and management from 10/25/02 through 4/22/03.

### 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 female who sustained a work related injury to her back on \_\_\_. The \_\_\_ chiropractor reviewer also noted that the diagnoses for this patient have included thoracic sprain/strain and thoracic spine

facet disorder. The \_\_\_ chiropractor reviewer further noted that treatment for this patient's condition has included physical therapy, pain management and oral medications, TENS unit, neuromuscular stimulator, an ice cap, spinal thoracic facet block and a right T5-T8 radiofrequency neurotomy. The \_\_\_ chiropractor reviewer explained that the patient had many qualifications to document the need for treatment and rehabilitation. The \_\_\_ chiropractor reviewer also explained that the patient did respond to the treatment rendered. Therefore, the \_\_\_ chiropractor consultant concluded that the office visit with manipulation, myofascial release, electric stimulation, ultrasound therapy, hot/cold pack therapy, prolonged evaluation and management from 10/25/02 through 4/22/03 were medically necessary to treat this patient's condition.

Sincerely,