

MDR Tracking Number: M5-04-1040-01

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 11-18-02.

The IRO reviewed postop monitoring, anesthesia, supplies, unusual travel and unlisted anesthesia procedure rendered from 12-17-01 through 12-21-01 that were denied based "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 03-30-04, 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	MARS	Reference	Rationale
12-17-01 through 12-21-01 (5 DOS)	22505-M1	1 unit @ \$400.00 X 5 DOS	\$0.00	F	\$200.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$200.00 X 5 DOS = \$1,000.00
12-17-01 through 12-21-01 (5 DOS)	22505-M2	1 unit @ \$400.00 X 5 DOS	\$0.00	F	\$200.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$200.00 X 5 DOS = \$1,000.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
12-17-01 through 12-21-01 (5 DOS)	22505-M3	1 unit @ \$400.00 X 5 DOS	\$0.00	F	\$200.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$200.00 X 5 DOS = \$1,000.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
12-17-01 through 12-21-01 (5 DOS)	22505-M4	1 unit @ \$400.00 X 5 DOS	\$0.00	F	\$200.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$200.00 X 5 DOS = \$1,000.00
12-17-01 through 12-21-01 (5 DOS)	22505-RT	1 unit @ \$400.00 X 5 DOS	\$0.00	F	\$200.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$200.00 X 5 DOS = \$1,000.00
12-17-01 through 12-21-01 (5 DOS)	22505-LT	1 unit @ \$400.00 X 5 DOS	\$0.00	F	\$200.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$200.00 X 5 DOS = \$1,000.00
12-17-01 through 12-21-01 (5 DOS)	27275-RT	1 unit @ \$400.00 X 5 DOS	\$0.00	F	\$303.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$303.00 X 5 DOS = \$1,515.00
12-17-01 through 12-21-01 (5 DOS)	27275-LT	1 unit @ \$400.00 X 5 DOS	\$0.00	F	\$303.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$303.00 X 5

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
							DOS = \$1,515.00
TOTAL		\$16,000.00	\$0.00				Requestor is entitled to reimbursement in the amount of \$9,030.00

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

Debra L. Hewitt
 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 12-17-01 through 12-21-01 in this dispute.

This Order is hereby issued this 13th day of May 2004.

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

March 19, 2004

Re: IRO Case # M5-04-1040-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical

records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient injured her neck and back in ___ when she attempted to lift a person into a sitting position. She was treated with physical therapy, chiropractic manipulation (without anesthesia) and medication. MRI and electrodiagnostic studies were obtained. Manipulation under anesthesia was performed and is the basis of this dispute.

Requested Service(s)

Post op monitoring, anes, supplies, unusual travel, unlisted anesth proc 12/17/01- 12/21/01

Decision

I disagree with the carrier's decision to deny the requested services.

Rationale

The patient had extensive conservative treatment prior to the services in dispute without benefit. Chiropractic manipulation without anesthesia also failed to be beneficial. MUA is a logical alternative for individuals who do not respond to traditional chiropractic manipulation. Adhesions to the spine tend to lock up the spine and prevent the necessary cavitation with traditional chiropractic manipulation. MUA allows the necessary cavitation to alleviate fixation of joints, restore normal movement of the spine and relieve splinting or guarding. The medical records indicate that the patient exhibited the indications for MUA, such as failed conservative chiropractic care, chronic or recurring pain, inflammation of the facet joint, restricted spinal ranges of motion, headaches of non-organic origin and severe pain. She also had no contraindications to MUA. Serial manipulations are recommended to prevent reaction to shock by attempting to do too much at one time.

Therefore, manipulations are performed on consecutive days. The documentation provided for this review was very detailed, showing objective and quantifiable findings that support the necessity of the services provided. Clinical monitoring is necessary post MUA until the patient reaches discharge criteria, and this is done on an hourly basis. The documentation provided supports this monitoring and discharge criteria.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.