

MDR Tracking Number: M5-04-1056-01

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 12-11-03.

The IRO reviewed neuromuscular stimulator and office visits rendered from 01-23-03 through 01-24-03 that were denied based upon “U”.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 03-15-04, 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
1-27-03 through 2-13-03 (8 DOS)	99213	\$480.00 (1 unit @ \$60.00 X 8 DOS)	\$0.00	N	\$48.00	96 MFG E/M GR (VI)(B)	Requestor provided relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$48.00 X 8 DOS= \$384.00
3-28-03	90801	\$270.00 (90 units)	\$0.00	R	\$3.00 per minute	Rule 133.307 (g)(3)(A-F)	R – Per TWCC 21 on file the carrier does not dispute psychiatric as

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
							part of the compensable injury. The requestor submitted relevant information to support delivery of the service. Therefore, reimbursement is recommended in the amount of \$270.00
TOTAL		\$750.00	\$0.00				Requestor is entitled to reimbursement in the amount of \$654.00

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 01-27-03 through 03-28-03 in this dispute.

This Findings and Decision and Order are hereby issued this 13th day of May 2004.

Debra L. Hewitt
 Medical Dispute Resolution Officer
 Medical Review Division

DLH/dlh

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

February 26, 2004

Re: IRO Case # M5-04-1056

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 his lower back and sacroiliac joint on ___ when he stepped on a fire truck and felt a sudden sharp pain in his lower back. He presented for chiropractic treatment on 1/20/03. X-rays, an MRI, and chiropractic treatment were performed.

Requested Service(s)

Neuromuscular stim, ovs 1/23/03-1/24/03

Decision

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

Rationale

The documentation provided for this review does not support the billing code 99213. The documentation lacks subjective complaints and objective findings to support this code. A 99213 code is not reasonable or necessary for each visit. A neuromuscular stimulator

is not reasonable or necessary this early in a treatment plan. It is over utilization and inappropriate.

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