

THIS DECISION HAS BEEN APPEALED. THE
 FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
 SOAH DOCKET NO. 453-05-1035.M5

MDR Tracking Number: M5-04-1399-01

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 1-12-04.

Dates of service prior to 1-12-03 were submitted untimely per above referenced rule and will not be considered in this decision.

The IRO reviewed therapeutic exercises, myofascial release, joint mobilization, neuromuscular re-education, office visits, hospital visit rendered from 1-13-03 through 3-14-03 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.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
1-22-03	99213	\$48.00	\$0.00	No	\$48.00	CPT Code Descriptor	MAR of \$48.00 X 11 dates = \$528.00 is recommended.
1-24-03			EOB				
1-27-03	97110 (4)	\$140.00	\$0.00		\$35.00 / 15 min		
1-29-03							MAR of \$140.00 X 11 dates = \$1540.00 is recommended
1-31-03	97112	\$35.00	\$0.00	No	\$35.00 / 15 min	CPT Code Descriptor	MAR of \$35.00 X 11 dates = \$385.00 is recommended
2-17-03				EOB			
2-19-03	97265	\$43.00	\$0.00	No	\$43.00	CPT Code Descriptor	MAR of \$43.00 X 11 dates = \$473.00 is recommended
2-21-03				EOB			
2-24-03	97250	\$43.00	\$0.00	No	\$43.00	CPT Code Descriptor	MAR of \$43.00 X 11 dates = \$473.00 is recommended
2-26-03							
3-16-03				EOB			
TOTAL							The requestor is entitled to reimbursement of \$3399.00.

On March 29, 2004, 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:

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services identified above. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline*.

This Decision is hereby issued this 7th 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 1-13-03 through 3-16-03 in this dispute.

This Order is hereby issued this 7th day of September 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

March 26, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-04-1399-01
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 39 year-old male who sustained a work related injury on ____. The patient reported that while at work he injured his neck, right upper back, and right shoulder when he attempted to load a metal cast onto a truck. Initially the patient was treated with electrical stimulation, ultrasound, cold/hot packs, neuromuscular reeducation, myofascial release, passive range of motion/active range of motion, and desensitization. On 10/2/02 the patient underwent an MRI of the cervical spine and right shoulder that showed disc herniations at C3-4 and C5-6, and a tear of the supraspinatus tendon and fluid in the glenohumeral joint and subacromial bursa. The patient underwent an orthopedic evaluation on 1/15/02 and was diagnosed with multi level cervical nucleus pulposus, right shoulder impingement, and right rotator cuff tear. The patient also received an injection to the right shoulder and was prescribed Motrin and Flexeril. The patient continued therapy. On 6/30/03 the patient underwent a discogram of the cervical spine that indicated an abnormal discogram at the C4-5 and C5-6 levels. The patient was then evaluated by a pain management specialist who recommended epidural steroid injections. On 8/27/03 the patient underwent the epidural steroid injections followed by physical therapy. Diagnoses for this patient's condition has included cervical herniated nucleus pulposus, impingement syndrome of the right shoulder, and rotator cuff tear.

Requested Services

Therapeutic exercises, myofascial release, joint mobilization, neuromuscular reeducation, office visits, hospital visit from 1/13/03 through 3/14/03.

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 39 year-old male who sustained a work related injury to his neck, right upper back, and right shoulder on ____. The ___ chiropractor reviewer also noted that the patient was treated with electrical stimulation, ultrasound, cold/hot packs, neuromuscular reeducation, myofascial release, passive range of motion/active range of motion, desensitization, and an injection to the right shoulder. The ___ chiropractor reviewer indicated that the patient underwent a discogram on 6/30/03 that was reported as abnormal and was then referred for a neurosurgical evaluation. The ___ chiropractor reviewer explained that due to the abnormal discogram, continued therapy was medically necessary. The ___ chiropractor reviewer also explained that the patient had responded well to the treatment from 1/13/03 – 3/14/03. Therefore, the ___ chiropractor consultant concluded that the therapeutic exercises, myofascial release, joint mobilization, neuromuscular reeducation, office visits, hospital visit from 1/13/03 through 3/14/03 were medically necessary to treat this patient's condition.

Sincerely,