

MDR Tracking Number: M5-04-1924-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 2-27-04.

The IRO reviewed office visits w/manipulations, myofascial release, electrical stimulation (unattended), mechanical traction, hot/cold packs, supplies, therapeutic exercises, and manual therapy techniques from 2-28-03 to 1-20-04.

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 5-6-04, 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.

Code 99080-73 was billed for date of service 11-24-03 and denied as "V – unnecessary medical"; however, per Rule 129.5, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; therefore, recommend reimbursement of \$15.00.

The above Findings and Decision is hereby issued this 18th day of November 2004.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division  
Enclosure: IRO Decision

## ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- In accordance with TWCC reimbursement methodologies regarding Work Status Reports for dates of service on or after August 1, 2003 per Commission Rule 134.202 (e)(8);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 2-28-03 through 1-20-04 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 18th day of November 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

Enclosure: IRO Decision

November 16, 2004

Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

**REVISED REPORT**  
**Items in dispute**

Re: Medical Dispute Resolution  
MDR #: M5-04-1924-01  
TWCC#:  
Injured Employee:  
DOI:  
SS#:  
IRO Certificate No.: 5055

Dear

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine who is currently on the TWCC Approved Doctor List.

### **REVIEWER'S REPORT**

#### **Information Provided for Review:**

TWCC-60, Table of Disputed Services & EOB's  
Correspondence from treating doctor – 04/09/03, 07/15/03 & 04/06/04  
Texas Back Institute progress notes – 12/09/03, 01/05/04, 02/03/04 & 03/04/04  
Physical therapy – 02/04/03 through 01/20/04  
Nerve conduction study – 11/24/03  
Radiology reports – 12/22/03, 12/09/03 & 01/05/04

#### **Clinical History:**

The patient was originally injured at work on \_\_\_\_. Treatments were received, and he was assessed a permanent whole body impairment of 5% on 7/7/00. Over the years, the patient had documented exacerbations of his original injury, which required additional treatment on a p.r.n. basis.

On previous exacerbations, the patient was able to receive minimal treatment and responded sufficiently without need for additional significant care. However, the records indicate when the patient returned because of a flare of his original injury, the treatment was not able to resolve his condition. At that time, the treating doctor made the appropriate referral and ordered appropriate diagnostic testing, which confirmed the patient was, in fact, experiencing significant problems.

**Disputed Services:**

Office visit w/manipulation, myofascial release, phys med. Treatment –1 area, supplies, therapeutic procedure, and manual therapy during the period of 02/28/03 through 01/20/04.

**Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were medically necessary in this case.

**Rationale:**

On each date of service that has been denied, there is sufficient clinical documentation to justify all treatment that was rendered on each date by the treating doctor. In conclusion, all denied services rendered during the period of 2/28/03 through 01/20/04 were, in fact, reasonable, usual, customary, and medically necessary for the treatment of this patient's on the job injury.