

MDR Tracking Number: M5-04-2476-01

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 February 25, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the issues of medical necessity. The office visits, myofascial release, joint mobilization, neuromuscular re-education, psychiatric diagnostic interview, and 3 units of therapeutic procedures from 02-25-03 through 06-19-03 **were** medically necessary. The offices visits, motor and sensory, somatosensory, and H/F reflex testing from 05-05-03 through 05-22-03 **were not** medically necessary. 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 06-23-04, 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	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
04-08-03	97265	\$43.00	\$0.00	No EOB	\$43.00	1996 Medical Fee Guideline	The requestor did not submit convincing evidence of carrier receipt of provider's request for EOB's, therefore no reimbursement recommended.
04-11-03	97265	\$43.00	\$0.00	No EOB	\$43.00	1996 Medical Fee Guideline	The requestor did not submit convincing evidence of carrier receipt of provider's request for EOB's, therefore no reimbursement recommended.
05-05-03 through 05-22-03	97545 x 14 days	\$1433.60 \$3584.00	\$0.00	U	\$64.00/per hour less 20% if non-CARF	1996 Medical Fee	The requestor received preauthorization #1032623 for the work hardening program and

	97546 x 14 days					Guideline	therefore is not subject to an IRO review. Recommend reimbursement of \$5017.60 in accordance with the 1996 MFG.	
TOTAL		\$5103.60					The requestor is entitled to reimbursement of \$5017.60.	

This Findings and Decision is hereby issued this 5th day of November 2004.

Patricia Rodriguez
 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 Order is applicable for dates of service 02-25-03 through 05-22-03 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 5th day of November 2004.

Roy Lewis, Supervisor
 Medical Dispute Resolution
 Medical Review Division

PR/pr

May 27, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2476-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- 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 who is familiar with the with the condition and treatment options at issue in this appeal. 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 40 year-old male who sustained a work related injury on ----- . The patient reported that while at work he was carrying an iron beam when he began to experience right-sided back pain with right leg pain. Initially the patient had been treated with one month of physical therapy and medications. A MRI of the lumbar spine was performed on 10/31/02 and was reported to have shown a 3-4mm central herniation at L4-5 associated with capsular swelling on the right side causing severe foraminal stenosis, and a few millimeters of central herniation associated with facet degeneration. The patient underwent an EMG/NCV on 11/21/02 that showed no electrophysiological evidence of lumbar radiculopathy, lumbosacral plexopathy, or distal mononeuropathy. The diagnoses for this patient have included lumbar discogenic pain, bilateral lumbar facet syndrome, bilateral sacroiliitis, myofascial pain syndrome. Treatment for this patient's condition has included therapeutic procedures, myofascial release, joint mobilization, and neuromuscular reeducation.

Requested Services

Office visits, therapeutic procedures, myofascial release, joint mobilization, neuromuscular reeducation, psychiatric diagnostic interview, motor nerve conduction study, sensory nerve conduction study, somatosensory testing, and H/F reflex study from 2/25/03 through 6/19/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Orthopedic note 11/12/02
2. EMG/NCV 11/21/02
3. ___ notes 1/29/03 –2/13/03
4. Progress Notes 2/20/03 – 10/14/03

Documents Submitted by Respondent:

1. Same as above

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a 40 year-old male who sustained a work related injury to his back on ----- . The ----- chiropractor also that the patient had been treated with myofascial release, joint mobilization, neuromuscular reeducation, therapeutic procedures, and a work hardening program, and had undergone psychiatric diagnostic interview, motor, sensory, and somatosensory and H/F reflex testing. The ----- chiropractor reviewer indicated that the patient did not require the testing that was performed on 6/19/03. The ----- chiropractor reviewer explained that the patient had already been diagnoses and had received extensive care that included 6 weeks of work hardening. The ----- chiropractor reviewer also explained that the additional testing would not produce any new information regarding this patient's condition. The ----- chiropractor reviewer indicated that the patient did not require supervised treadmill or bike therapeutic procedures. The ----- chiropractor reviewer noted that the patient underwent epidural steroid injections and that treatment rendered to this patient other than the treadmill/bike therapy was required to help increase the efficacy of the injections. The ----- chiropractor reviewer explained that this patient's treatment plan required a multi-disciplinary approach to resolve. However, the ----- chiropractor reviewer also explained that although the treatment this patient received was helpful in returning him to work, portions of the treatment rendered were not medically necessary. Therefore, the ----- chiropractor consultant concluded that the office visits, motor and sensory, somatosensory, and H/F reflex testing from 5/5/03 through 5/22/03 were not medically necessary to treat this patient's condition. However, the ----- chiropractor consultant further concluded that the office visits, myofascial release, joint mobilization, neuromuscular reeducation, psychiatric diagnostic interview, and 3 units of therapeutic procedures from 2/25/03 through 6/19/03 were medically necessary to treat this patient's condition.

Sincerely,