

MDR Tracking Number: M5-02-2314-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the treatment/services rendered were not medically necessary. The treatment/services included the following CPT codes: 95851, 97750-MT, 99213, and 97110.

Based on review of the disputed issues within the request, the Division has determined that the treatment/services, CPT codes 95851, 97750-MT, 99213, and 97110, rendered were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 8/14/02 to 10/2/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 26th day of, June 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

Enclosure: IRO decision

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 17, 2002

Re: IRO Case # M5-02-2314

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, Rule 133.308 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 IRO's, 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 licensed by the State of Texas. 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 ___ reviewer who reviewed this case has determined that, based on the medical records provided, the requested treatment was not medically necessary. Therefore, ___ agrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

History

This case involves a 46-year-old female injured on ___ and developed dizziness, headache, neck pain and pain on her right side.

Services in Medical necessity Dispute

Chiropractic treatment , temperature gradient studies, exercises

Decision and Rationale

1. I agree with the carrier's decision to deny the services rendered 8-17-01 and 8-23-0 due to lack of any documentation to support treatment for CPT code 99213.
2. I agree with the carrier's decision to deny the services rendered on 8-24-01 due to lack of documentation to support the treatment. "Decreased range of motion" as stated by the provider, means nothing unless degrees of restriction or percentage of restriction are noted, and no degrees or percentage of restriction were documented. The doctor states that there is "tenderness and soreness" in the neck and trapezius muscle but fails to describe the frequency and intensity of tenderness and soreness. Also, the doctor states there are muscle spasms but does not describe the intensity of the spasm as being slight, mild, moderate or severe.
3. I agree with the carrier's decision to deny the requested services rendered on 9-4-01 and 9-19-01 for CPT code 93740-WP, temperature gradient studies. The patient's subjective

complaints and objective findings do not support testing to the extent of these studies. This is an unnecessary service for a very basic subjective complaint that should be addressed with chiropractic manipulation and deep tissue massage. If there were an associated radiculopathy, then an MRI would be beneficial.

4. I agree with the carrier's decision to deny CPT code 97710 for 9-10, 17, 18, 19, 20, 24, 26, 27, 28 -01, and for 10-1, 3-01. The reasons are the lack of documentation as stated in paragraph #2, and these exercises can easily be done in a group setting or at home, and one on one instruction or demonstration is not necessary.

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

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,

President