

MDR Tracking Number: M5-02-3132-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The IRO reviewed chiropractic treatment rendered from 9-17-01 to 2-13-02 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 March 7, 2003, 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:

Services denied without an EOB will be reviewed in accordance with *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
8-21-01	99205 99080-61 95851 97750MT 99070 99070	\$160.00 \$70.00 \$40.00 \$172.00 \$18.33 \$8.00	\$0.00	No EOB	\$137.00 \$70.00 \$36.00 \$172.00 \$18.33 \$8.00	Medicine GR (I)(E)(3) CPT Code Description General Instructions GR (IV) Rule 133.106(e) Medicine GR (I)(D)(1)(e)	Documentation supports initial evaluation reimbursement of \$137.00 is recommended.  9 page Narrative report supports reimbursement of \$70.00.  Lumbar ROM report supports reimbursement of \$36.00.

							<p>Lumbar Muscle testing was performed per MFG reimbursement of \$43.00 is recommended.</p> <p>Requestor noted "Home therapy refreezable ice packs...Analgesic balm is supplied for pain control." Reimbursement of \$18.33 + \$8.00 = \$26.33.</p>
8-27-01 9-7-01 1-29-02 3-11-02 4-1-02	99213	\$50.00	\$0.00	No EOB	\$48.00	CPT Code Descriptor	Documentation supports billed service, reimbursement of 5 X \$48.00 = \$240.00
TOTAL							The requestor is entitled to reimbursement of \$ 516.33.

**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 \$516.33 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 8-21-01 through 4-1-02 in this dispute.

This Order is hereby issued this 5th day of August 2003.

Elizabeth Pickle  
 Medical Dispute Resolution Officer  
 Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

**AMENDED LETTER**  
NOTE: Requested Service Dates

January 16, 2003

Rosalinda Lopez  
Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
4000 South IH-35, MS 48  
Austin, TX 78704-7491

RE: MDR Tracking #: M5-02-3132-01  
IRO Certificate #: 4326

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care.

\_\_\_ health care professional has signed a certification statement stating 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 the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 51 year old female sustained a work-related back injury on \_\_\_ while lifting boxes. She was treated for some time allopathically, medication management, injections and physical therapy. According to the clinical records, she made satisfactory progress until she suffered an exacerbation of some kind with a worsening of symptoms. She has undergone an exhaustive course of physical medicine with little to no apparent significant relief of symptoms. An MRI examination revealed minimal disc bulging, however a discogram indicated some annular tearing and discogenic concordant pain. She has received chiropractic treatment at the frequency of approximately every two weeks, from 09/17/01 to 02/13/02.

Requested Service(s)

Chiropractic treatment rendered from 09/17/01 to 02/13/02

Decision

It has been determined that the chiropractic treatment from 09/17/01 to 02/13/02 was not medically necessary.

Rationale/Basis for Decision

The course of treatment initiated by the chiropractor is inconsistent with generally accepted standards of care within the chiropractic profession in regards to frequency. According to the documentation presented for review, the patient was seen approximately two times per month to “manage” while referrals and diagnostic procedures were being arranged. This frequency is not only inconsistent with standards of care for similar cases, it could not have been, in all medical probability, reasonably expected to bring about any significant or permanent resolution to this case and the chronic symptomatology the patient displayed at the time of the initial examination. Furthermore, the frequency of chiropractic care represented in the documentation, could be considered to palliative at best and not corrective. In addition, it was noted in the clinical records from the first referral entity that mood and psychosocial issues were suspected. It would be unlikely at that juncture to expect further gains in progress through physical medicine, especially at the frequency of two times per month, without additional attention given to these issues and to the other objective findings observed at that time. Therefore, the chiropractic treatment from 09/17/01 to 02/13/02 was not medically necessary.

Sincerely,