

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO: 453-04-5858.M5

MDR Tracking Number: M5-04-0845-01

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 10-31-03.

The IRO reviewed special report, therapeutic exercises, neuromuscular reeducation, office visits, physical performance test, supplies and materials, disposable underpants, syringe w/ needle, lidocaine injection, fluoroscopy, and NOC antineoplastic drug from 12-6-02 through 4-17-03.

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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 2-18-04, 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
4-2-03	99071	\$45.00	\$0.00	No EOB	DOP	Rule 133.307(g)(3) (A-F)	Requestor failed to submit relevant information to meet DOP criteria. No reimbursement recommended.
TOTAL		\$45.00					The requestor is not entitled to reimbursement.

This Decision is hereby issued this 16th day of April 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

February 24, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Determination B**

RE: MDR Tracking #: M5-04-0845-01

___ 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 33 year-old female who sustained a work related injury on -----. The patient reported that while at work she fell injuring her lower back, right hip, ankle and left wrist. The patient was evaluated in the emergency where she was treated with sutures to the right knee and medications. On 5/25/01 the patient was evaluated by a chiropractor and started treatment with physical therapy, however this was discontinued due to an increase in the patient's knee pain. An MRI of the right knee was performed on 6/27/01 that indicated minimal sprain of the anterior cruciate ligament without evidence of disruption, Grade I chondromalacia patella, and a fibrous plica was demonstrated in the suprapatellar fat. The patient was referred to an orthopedic surgeon who performed arthroscopic surgery to the right knee that consisted of chondroplasty and debridement on 5/15/02. A MRI report of the lumbar spine dated 9/21/01 showed focal central disc bulge at the L4-L5 level with patent neural foramen bilaterally. An EMG study of the lower extremities dated 9/13/01 showed mild right L5 radiculopathy, manifested only by a decrease seen in right peroneal F-wave frequency, and no clear evidence of entrapment neuropathy at the right knee. An evaluation dated 4/17/03 indicated that the

diagnoses for this patient have included lumbar intravertravertebral disorder without myelopathy, lumbar radiculopathy, and right knee medical meniscus tear (resolved). On 4/7/03 the patient underwent a single epidural steroid injection at the L4-L5 levels.

Requested Services

Special report, therapeutic exercises, neuromuscular reeducation, office visits, physical performance test, supplies and materials, disposable underpants, syringe with needle, Lidocaine injection, fluoroscopy, and NOC Antineoplastic drug from 12/6/02 through 4/17/03.

Decision

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

Rationale/Basis for Decision

The chiropractor reviewer noted that this case concerns a 33 year-old female who sustained a work related injury to her low back, right hip, ankle and left wrist on _____. The _____ chiropractor reviewer also noted that the diagnoses for this patient have included lumbar intravertravertebral disorder without myelopathy, lumbar radiculopathy, and right knee medical meniscus tear (resolved). The _____ chiropractor reviewer further noted that treatment for this patient's condition has included an epidural steroid injection, physical therapy, and arthroscopic surgery to the right knee. The chiropractor indicated that the patient underwent extensive physical therapy for treatment of the low back and knee injury. The _____ chiropractor reviewer noted that the patient was evaluated and deemed to be at maximum medical improvement with a 9% whole body impairment on 10/10/02. The _____ chiropractor reviewer indicated that the patient denied complaints of radicular pain at that time. The _____ chiropractor reviewer explained that the documentation provided does not indicate why the patient continued treatment through December 2002 or what triggered the low back and leg pain in January 2003. The _____ chiropractor reviewer also explained that the treatment this patient received did not meet the TWCC criteria for returning her back to work, resolving her condition, or eliminating her pain. The _____ chiropractor reviewer further explained that the patient was not diagnosed with radicular pain until 1 ½ years after the injury sustained on 5/23/01. Therefore, the chiropractor consultant concluded that the special report, therapeutic exercises, neuromuscular reeducation, office visits, physical performance test, supplies and materials, disposable underpants, syringe with needle, Lidocaine injection, fluoroscopy, and NOC Antineoplastic drug from 12/6/02 through 4/17/03.

Sincerely,