

MDR Tracking Number: M5-04-1203-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General 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 12-31-03.

Dates of service prior to 12-31-02 were submitted untimely per above referenced rule and will not be considered further in this decision.

The IRO reviewed therapeutic exercises, therapeutic activities, neuromuscular re-education, manual traction, physical medicine procedure, myofascial release, office visits, physical performance test rendered from 1-6-03 through 5-16-03 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 17, 2004, 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:

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services identified above. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
1-24-03 2-11-03 4-14-03 4-16-03	97110(4)	\$140.00	\$0.00	No EOB	\$35.00 / 15 min X 4 = \$140.00	CPT Code Descriptor	MAR reimbursement of 4 dates X \$140.00 = \$560.00 is recommended.
1-24-03 2-12-03 4-14-03 4-16-03	97530	\$140.00	\$0.00	No EOB	\$35.00 / 15 min	CPT Code Descriptor	MAR reimbursement of 4 dates X \$140.00 = \$560.00 is recommended.
1-24-03	97250	\$43.00	\$0.00	No EOB	\$43.00	CPT Code Descriptor	MAR reimbursement of \$43.00 is recommended.
3-24-03	29540	\$40.00	\$0.00	N	\$30.00	CPT Code Descriptor	Requestor did not submit medical record to support strapping ankle and challenge carrier's position per Rule 133.307(g)(3); therefore, no reimbursement is recommended.
TOTAL							The requestor is entitled to reimbursement of \$1163.00 .

IV. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is entitled to reimbursement for CPT code(s) 97110, 97530 and 97250 in the amount of **\$1163.00**. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **\$1163.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 7th day of September 2004.

Elizabeth Pickle
 Medical Dispute Resolution Officer
 Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

March 12, 2004

**Re: IRO Case # M5-04-1203
IRO Certificate #4599**

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, Rule133.308 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 IROs, 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, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. 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 determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient injured his neck and left shoulder in ___ when he was lowering wooden trusses with the use of a crane. MRIs of the cervical spine and left shoulder were obtained, as well as x-rays. The patient was treated with medication, epidural steroid injections, physical therapy, chiropractic treatment and a work hardening program. The patient initially saw his treating D.C. in May 2002.

Requested Service(s)

Therap exercises, therap activities, neuromuscular re-ed, manual traction, phys med proc, myofascial release, ovs, phys perf test 1/6/03-5/16/03

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient had extensive chiropractic treatment prior to the dates in dispute. Treatment notes presented for this review begin with the date 11/5/02. As of this date the patient had a VAS of 3/10. As of 1/6/03 his VAS was still 3/10. The VAS rating did not change throughout the period in dispute. After over a year of intensive chiropractic treatment his VAS was still 3/10. The treatment notes provided for this review are repetitive and lack objective, quantifiable findings to support continued treatment. Absent were regular re-exam reports to support treatment for the dates in dispute. Subjective complaints are also lacking. The documentation provided did not support the use of therapeutic activities and exercises. There was no specific description of the activities and exercises being used. The treating D.C. stated in a letter on 2/12/04 that the patient had had 127 visits in his office. This is excessive and inappropriate. The patient's initial VAS was 6/10, and after 127 visits it was 3/10. The patient's ongoing and chronic care did not produce measurable or objective improvement. The records provided for this review suggest that the patient plateaued in a diminished condition about two months prior to the period in dispute, and further treatment was unreasonable and ineffective in relieving symptoms or improving function.

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