

MDR Tracking Number: M5-04-1309-01

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, 133.307 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 01-13-04.

The Medical Review 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 joint mobilization, myofascial release, therapeutic exercises, manual therapy, physical performance test, therapeutic activities, and work hardening program (initial and additional hours) rendered from 4/7/03 through 8/25/03 with "U" or "V" denial codes were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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 April 13, 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.

CPT code 97545 for 5/29/03 through 8/13/03, 8/15/03, 8/22/03 and 8/25/03: No HCFAs in file to reflect proof of billing, therefore, in accordance with the Rule 133.307 (e)(2)(A) **reimbursement is not recommended.**

CPT code 97546 for 5/29/03 through 8/21/03, and 8/25/03: No HCFAs in file to reflect proof of billing, therefore, in accordance with the Rule 133.307 (e)(2)(A) **reimbursement is not recommended.**

CPT code 99213 for 4/29/03: Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's for this service in accordance with Rule 133.307 (e)(2)(A). Also, the requestor did not submit a HCFA to reflect proof of billing. Therefore, **reimbursement is not recommended.**

The request for reimbursement is denied as outlined above, and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 18th day of October 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

NOTICE OF INDEPENDENT REVIEW DECISION

March 31, 2004

Re: IRO Case # M5-04-1309-01
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 her back on ___ when she pulled a bakery rack and felt a ‘pop’ in her low back with onset of pain. She was treated with physical therapy prior to presenting to her treating D.C. She has been treated with physical therapy, epidural steroid injections and chiropractic treatment. An MRI was obtained.

Requested Service(s)

Joint mobilization, myofascial release, therap exercises, manual therapy, phys perf test, therap activities, work hardening/conditioning – initial & additional hrs, 4/7/03-8/25/03

Decision

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

Rationale

The patient had participated in a course of physical therapy and chiropractic treatment prior to the dates in dispute without relief of symptoms or improved function. According to an IME report dated 6/5/03, the patient continued to be in constant pain without any lasting relief despite over three months of chiropractic treatment and a work hardening program. On 8/9/03 the patient still reported a VAS of 8-9 on a scale of ten, after months of intensive conservative treatment. The 6/5/03 IME report also noted symptom magnification and less than reliable effort on an FCE. Another report stated that chiropractic treatment had failed because manipulation was too painful, and manipulation under anesthesia was recommended. The patient had received a fair trial of physical therapy and chiropractic, which failed to be beneficial. Treatment during the period in dispute was over utilized and inappropriate. The medical records provided for this review lack objective, quantifiable findings to support treatment, and do not show how the disputed treatment was medically necessary.

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