

MDR Tracking Number: M5-04-1621-01

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 02-05-04.

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 myofascial release, therapeutic exercises, office visits, mechanical traction, unlisted service, chiropractic manipulative treatments, massage therapy, and manual therapy techniques rendered from 4/02/03 through 10/31/03 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 21, 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 99082** for dates of service 7/11/03 through 8/27/03 was denied by the carrier with "F", fee guideline reduction. The requestor did not submit documentation to support delivery of service for the above dates, therefore, **reimbursement is not recommended.**
- **CPT code 97537** for date of service 9/19/03 was denied by the carrier with "N", not appropriately documented. The requestor did not submit documentation to support delivery of service on this date, 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 20th day of October 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

April 15, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-1621-01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine who is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

Correspondence
H&P and office notes
Physical therapy notes
FCE/EMG
Operative and Radiology reports

Clinical History:

This 43-year-old female injured her back in a work-related accident on ___. She was taken to the emergency room where she was treated on an emergency basis, but then presented herself to a doctor of chiropractic who initiated her conservative care.

Disputed Services:

Myofascial release, therapeutic exercises, office visits, mechanical traction, unlisted service, chiropractic manipulation treatment-spine, massage therapy, and manual therapy technique during the period of 04/02/03 through 10/31/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

After approximately 8 weeks of conservative care, the doctor of chiropractic should have recognized the fact that this patient was not responding to care, and changed the course of care. He continued to render the same services, for several months with little or no variation to the prescribed treatment plan. The office notes consisted of little or no variation in the language on a day to day basis. The records provided for review reflected that no legitimate reexaminations were performed on this patient that would warrant the prolonged care. As a result, the medical necessity of the treatment rendered in this case cannot be supported. Furthermore, an examination was performed on 04/30/03 and the reviewer concurs with the opinion of the examiner that the patient had reached maximum medical improvement at that time and that "further therapy, medications for her back [would] not improve the situation" and concluded that "treatment for this injury should be completed at this point."

Sincerely,