

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

SOAH DOCKET NO. 453-05-3187.M5

MDR Tracking Number: M5-04-3173-01

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. The dispute was received on 5-21-04.

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 office visits, therapeutic exercises, myofascial release, office visits with manipulations and manual therapy from 5-21-03 through 9-22-03 were not medically necessary.

On 7-8-04 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 carrier denied CPT Code 99080-69 with a V for unnecessary medical treatment based on a peer review, however, the TWCC-69 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Per Rule 134.202(e)(6)(A)(iv), the preparation and submission of reports is included in the MMI/IR examination. **Therefore, reimbursement is not recommended.**

This Decision is hereby issued this 19th day of November 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

NOTICE OF INDEPENDENT REVIEW DECISION

August 18, 2004

Amended Letter 11/15/04

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-3173-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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. TMF's 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 TMF 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 54 year-old male suffered a whiplash type injury on ____ due to a bus accident, resulting in pain in his mid and low back. His diagnoses are thoracic disc protrusions, lumbar spine disc protrusions, left-sided sacroiliitis, and whiplash syndrome.

Requested Service(s)

Office visits, therapeutic exercises, myofascial release, office visits with manipulations, and manual therapy from 05/21/03 through 09/22/03.

Decision

It is determined that there was no medical necessity for the office visits, therapeutic exercises, myofascial release, office visits with manipulations, and manual therapy in the treatment of this patient's medical condition from 05/21/03 through 09/22/03.

Rationale/Basis for Decision

Based on the history and the 09/19/02 examination, the medical necessity of 8 weeks of physical medicine treatment was supported. However, further care beyond 05/14/03 was not indicated because the patient obtained no relief from the ongoing treatments. Specifically, the documentation revealed that the patient's pain rating was a 6 on a scale of 10 on 09/17/02 at the initiation of treatment, but the pain was a 7 on the scale of 10 near the end of care on 05/14/03. In the absence of any objective reexamination data such as shoulder and/or cervical ranges of motion showing functional improvement to otherwise support the care rendered, there is no basis to continue a therapy that did not provide any benefit. Therefore, it is determined that there was no medical necessity for the office visits, therapeutic exercises, myofascial release, office visits with manipulations, and manual therapy in the treatment of this patient's medical condition from 05/21/03 through 09/22/03.

Sincerely,