

MDR Tracking Number M5-04-4240-01

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 (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 August 16, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. 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 the only issue** to be resolved. The chiropractic manipulation treatment-spinal on 4/15/04 and 5/13/04 **were found to be medically necessary**. The chiropractic manipulations and all office visits rendered from 9/16/03 through 6/10/04 **were not found to be medically necessary**. The respondent raised no other reasons for denying reimbursement of the chiropractic manipulations and office visits.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 4/15/04 and 5/13/04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 1st day of November 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

October 28, 2004

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

Re: Medical Dispute Resolution
MDR #: M5-04-4240-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ 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 ___ 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 and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

- Letter of medical necessity 07/19/04
- Office notes 09/16/03 – 06/10/04
- Radiology report 06/09/03

Information provided by Respondent:

- Peer review 07/28/03

Information provided by Pain Mgmt. Specialist:

- Office notes 06/20/03 – 07/18/03
- Nerve conduction study 06/20/03

Clinical History:

This is a claimant is a 19-year-old male who was working on ___, when he was injured. Apparently, he twisted and sustained injury to his lower back. MRI on 06/09/03

revealed L3/L4 disc protrusion or herniation and a focal displacement to the right on disc level L1 through L2. This review is related to denial of claims following a peer review of 07/28/03.

Disputed Services:

Office visits and chiropractic manipulation treatment-spinal during the period of 09/16/03 thru 06/10/04.

Decision:

The reviewer partially agrees with the determination of the insurance carrier as follows:

Medically Necessary:

Chiropractic manipulation treatment-spinal on 04/15/04 and 05/13/04.

Not Medically Necessary:

All office visits and all other chiropractic manipulation other than that stated above

Rationale:

99213 [9 office visits] dates of service 09/16/03 through 06/10/04.

Worker's compensation claimants may have problems, which require decision making for treatment and referrals. It is generally accepted that the treating physician, in the presence of the injured employee, is in a better position to determine proper treatment and/or referrals and to address questions presented by the injured employee. However, the documentation provided for review failed to support the use of the office visit code 99213.

Additional Comment:

Of note, the carrier failed to provide a peer review report that recommended specific denials for the office visit charges. The carrier paper claim reviewer's blanket denial of future care was, apparently, based on limited knowledge of the patient's condition.

Sincerely,