MDR Tracking Number: M5-03-0170-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 **or January 1, 2003** and Commission Rule 133.305 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 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 office visits on 11-19-01 through 11-30-01, 12-20-01 through 12-27-01, 1-17-02, 1-18-02, 4-08-02 through 4-18-02, 5-17-02, and 6-12-02; office visits/manipulations on 11-12-01 and 11-14-01, and physical therapy sessions 12-20-01 through 12-27-01, 4-8-02, 4-10-02, 5-29-02, and 6-12-02 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 Division has determined that **medical necessity was not the only issue** to be resolved. There are unresolved fee issues.

Per Rule 133.307 (g) (3), the Division notified the parties and required the requestor to submit two copies of additional documentation relevant to the fee dispute. The 14-day Notice was faxed on 2-12-03. The requestor did not respond to the Notice.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12/20/01	97035 97265 97110 (2)	$ 26.00 $ 50.00 $ 80.00	0.00	Z	$22.00 $43.00 $35.00 ea 15 min	TWCC Rule 134.600 (h)(10)	Preauthorization is required for physical therapy rendered after the first eight weeks of treatment. No documentation was submitted to support preauthorization approval. No reimbursement recommended.
12/26/01	97035 97265 97110 (2)	$ 26.00 $ 50.00 $ 80.00					
12/27/01	97035 97265 97110 (2)	$ 26.00 $ 50.00 $ 80.00					
TOTAL		$468.00	0.00				The requestor is not entitled to reimbursement.

This Findings and Decision is hereby issued this 11th day of April 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

November 20, 2002

Re: IRO Case # M5-03-0170

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 IRO's, 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 is a Certified Strength and Conditioning Specialist. 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, based on the medical records provided, is as follows:

History
In ___ the patient sustained an injury from sitting eight to ten hours per day performing continual repetitious movements of data entry and taking orders. She received extensive therapy, and four surgeries were performed.

Requested Service(s)
Chiropractic care 11/12/01 through 6/12/02

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

Rationale
The documentation provided fails to support the treatment as reasonable or necessary. The documentation fails to provide valuable subjective complaints and objective findings to support the need for chiropractic manipulation of the spine. All documentation submitted pertains to the shoulder and elbow. A peer review on 5/1/02 recommended chiropractic treatment for dates 3/22/02 through 4/5/02 only. It was recommended that any additional treatment beyond those dates would require documentation to support necessity. The documentation submitted did not support the need for continued chiropractic treatment beyond 4/5/02.

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

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,