MDR Tracking Number: M5-03-0890-01

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 and Commission Rule 133.305 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 IRO reviewed chiropractic treatment rendered from 12-13-01 to 6-14-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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 June 16, 2003, 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 following table identifies the disputed services and Medical Review Division's rationale:

Services that were denied without an EOB will be reviewed in accordance with *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-27-01	99213	$50.00	$0.00	No EOB	$48.00	CPT Code description Evaluation & Management GR (IV)	A report to support service billed was not submitted; no reimbursement is recommended.
3-22-02	97265 97250 97124	$43.00 $43.00 $20.00	$0.00	A	$43.00 $43.00 $15.00	Rule 134.600	Physical therapy services do not require preauthorization. A report to support service billed was not

							submitted; no reimbursement is recommended.
1-3-02 2-7-02 3-8-02 4-5-02	99213	$50.00	$48.00	F	$48.00	MFG MAR	According to the EOBs these services were paid in accordance with MFG.
TOTAL							The requestor is not entitled to reimbursement.

This Decision is hereby issued this 22nd day of August 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

February 18, 2003

Re: IRO Case # M5-03-0890

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. 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 his lower back on ___. He was treated with chiropractic treatment and epidural steroid injections. He was declared to be at MMI on 4/18/96 with a 16% impairment rating.

Requested Service
Chiropractic services 12/13/01 through 6/14/02

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

Rationale
The patient has had extensive chiropractic treatment and physical therapy with little, if any, permanent relief of his symptoms. The documentation presented for this review states that the patient had significant relief after the first epidural steroid injection. I do not understand why epidural steroid injections were not considered earlier, based on the documentation that chiropractic treatment was providing little therapeutic relief of the patient's symptoms. It appears from the records provided that the patient's condition plateaued in a diminished condition several years ago, and that possible over utilization or inappropriate treatment may have led to physician dependence. Chiropractic treatment had failed. Therefore, the treatment 12/13/01 through 6/14/02 was not necessary and not in the best interest of the patient. All treatment after an MMI date must be reasonable and effective in relieving symptoms or improving function. The documentation presented by the treating doctor has not shown how the disputed services were necessary.

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

Sincerely,