MDR Tracking Number: M5-03-1095-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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. This dispute was received on 1-7-03.

The IRO reviewed chiropractic treatment rendered from 2-8-02 to 8-20-02 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 April 4, 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:

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MAR$ (Maximum Allowable Reimbursement) | Reference | Rationale |
|---|---|---|---|---|---|---|---|
| 2-8-02<br>2-22-02<br>3-12-02<br>3-29-02 | 95851 | $108.00 | $0.00 | G | $36.00 ea | Medicine GR (I)(E)(2) and (4) | Office visit and physical therapy services were billed on this date. ROM testing is not global to these services; therefore, the insurance carrier inappropriately denied reimbursement based upon |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | "G". Cervical, Lumbar and wrist ROM reports support billed service. Therefore, 4 dates X $108.00 = $432.00. |
| 2-25-02<br>3-13-02 | 97750 (X3) | $129.00 | $0.00 | G | $43.00/ body area | Medicine GR (I)(E)(2) and (3) and (I)(D)(1) | Office visit and physical therapy services were billed on this date. ROM testing is not global to these services; therefore, the insurance carrier inappropriately denied reimbursement based upon "G". Spine and Upper extremity muscle testing was performed; therefore, reimbursement of 2 body areas X $43.00 = $86.00 X 2 dates = $172.00. |
| 4-19-02 | 99213 | $48.00 | $0.00 | G | $48.00 | Evaluation & Management GR (IV) | Based upon EOB office visit was the only service billed on this date; therefore, not global. Reimbursement of $48.00 is recommended. |
| TOTAL | | | | | | | The requestor is entitled to reimbursement of **$652.00.** |

**ORDER.**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 Decision is applicable for dates of service 2-8-02 through 8-20-02 in this dispute.

This Decision is hereby issued this 13th day of October 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

**IRO Certificate #4599**

## NOTICE OF INDEPENDENT REVIEW DECISION

March 31, 2003

**Re: IRO Case # M5-03-1095**

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 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 ___ reviewer who reviewed this case has determined that, based on the medical records provided, the requested treatment was not medically necessary. Therefore, ___ agrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

History

The patient was reportedly injured on ___. The injury was due to repetitive movements of lifting cases weighing twenty pounds. It is reported that the patient's pain began in December, 2001. She complained of neck, lower back and right wrist pain. The patient has received medication, chiropractic care, exercises, physical therapy, work hardening and extensive testing for her injuries.

Requested Service(s)
Office visits, manipulations, range of motion, physical therapy, x-ray, muscle testing, NCV study, physical performance testing, DME 3/21/02-8/20/02

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

Rationale
The documentation presented for this review is extensive, but is very non-specific and repetitive. The treatment notes appear to be unchanged throughout the treatment period. The documentation fails to correlate subjective complaints and objective findings with treatment protocol. The patient's response to treatment was poor during the entire treatment period. In the impairment rating report dated 7/18/02 the patient's subjective complaints and objective findings were unchanged from the patient's initial visit on 2/7/02. Therefore the treatment protocol is questionable.
The patient was treated on a regular basis for several weeks prior to the dates in dispute. There is little, if any, documented proof that that earlier treatment was beneficial or effective in relieving the patient's symptoms.
The patient's subjective complaints and objective findings do not correlate clinically for use of temperature gradient studies. The necessity of a conditioning or multi disciplinary work hardening program is not supported by the documentation presented. The documentation fails to show the need for therapeutic exercises. The doctor fails to correlate the patient's subjective complaints and objective findings with the need for the exercises. The patient's lack of progress during the first few weeks of treatment would contraindicate the use of exercises at the time they were initiated. The documentation does not show the need for any of the disputed treatment.

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

Sincerely,

_____