

MDR Tracking Number: M5-03-1203-01

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. This dispute was received on 1-16-03.

The IRO reviewed chiropractic treatment rendered from 8-12-02 to 11-5-02 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. The insurance carrier denied office visits and physical therapy services denied based upon, "D," "N," "F," and "No EOB." These services will be reviewed in accordance with the *Medical Fee Guideline*.

On June 18, 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 requestor did not submit medical records to support services denied based upon, "D," "N," "F," and "No EOB". Therefore, reimbursement is not recommended.

This Decision is hereby issued this 19th day of September 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

June 6, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-1203-01
IRO Certificate #: IRO4326

The ___ 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 ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ 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. ___ 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 ___ 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 patient sustained an injury while moving medium sized boxes on ___. He reports that after bending down, his back started hurting, and radiated down his right lower extremity. The patient began chiropractic treatment on 07/24/02.

Requested Service(s)

Supplies, office visits, manipulations, and physical therapy from 08/12/02 through 11/05/02

Decision

It is determined that the supplies, office visits, manipulations, and physical therapy from 08/12/02 through 11/05/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The reviewed medical record does not coincide with the level of services applied by the provider from 08/12/02 through 11/05/02. It is appropriate for this patient to engage in chiropractic applications; however, there is no quantitative/qualitative data that would warrant continued applications. In addition, there is no diagnostic data provided for review which correlates the patient's subjective pain complaints with objective diagnostic evidence.

There is no documentation that establishes if the applied therapeutics were beneficial in the treatment of the patient's medical condition. The medical record established a baseline active range of motion on 07/24/02 that was not assessed again until the 12/17/02 impairment rating. In addition, the record does not sufficiently establish a measurable baseline to gauge the provider's application or treatment algorithm. Therefore, it is determined that the supplies, office visits, manipulations, and physical therapy from 08/12/02 through 11/05/02 were not medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- *Clinical guideline on low back pain.* American Academy of Orthopedic Surgeon's; 1999. 16p.
- *Overview of implementation of outcome assessment case management in the clinical practice.* Washington State Chiropractic Association; 2001. p54.

Sincerely,