MDR Tracking Number: M5-03-1283-01

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 Medical Review Division has reviewed the IRO decision and determined, the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore, the **requestor did not prevail** in the IRO decision. 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 the only issue** to be resolved. Six weeks of therapy treatment, including two weeks (3 times per week x 3) of passive therapy, two weeks (3 times per week x 3) of active therapy and two weeks (2 times per week x 3 units) of active therapy were found to be medically necessary. The all dates of service rendered were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these six weeks of therapy treatment charges.

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 2/26/02 through 5/13/02 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 5th day of August 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/cl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 29, 2003

Re: IRO Case # M5-03-1283-01

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 was injured on___ when a large roll of material fell from a rack and struck him. He was treted with physical therapy, manipulation, therapeutic exercises, ESIs and medication.

Requested Service(s)
Office visits, physical therapy, range of motion and muscle testing, required report, unlisted neurological or neuromuscular diag. procedure 2/26/02 – 5/13/02

Decision

I agree in part and I disagree in part with the carrier's decision to deny the requested treatment

Rationale

The patient's condition should have resolved within six weeks of the start of treatment based on the diagnosis reported. The documentation presented for this review supports a causal relationship between the condition and the date of injury. The frequency and length of treatment was excessive for the diagnosis and lack of response to treatment.

Six weeks of treatment was medically appropriate. The documentation presented does not support the need for any diagnostic testing (97750 MT) or a one-on-one therapeutic exercise program (97110) A home-based exercise program would have been appropriate. CPT Code 99213 was billed excessively and the documentation presented fails to show its necessity for the dates in dispute.

The following was reasonable and appropriate:

1. Two weeks of care, 3 times per week not to exceed three units of care per session, passive only.
2. Two weeks of care, 3 times per week not to exceed three units of care per session, active only.
3. Two weeks of care, 2 times per week, not to exceed three units of care per session, active only.

The documentation presented fails to show any relief of symptoms or functional improvement. Chiropractic treatment was ineffective and over utilized and has failed to be beneficial to the patient.

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

Sincerely,