MDR Tracking Number: M5-03-1318-01

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 1-27-03.

The IRO reviewed outpatient services rendered from 2-11-02 through 9-4-02 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 May 30, 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
2-5-02 2-21-02 2-25-02 8-16-02	99213MP	$48.00	$0.00	No EOB	$48.00	Medicine GR (I)(B)(1)(b)	
2-7-02	97545WH	$102.40	$0.00	No EOB	$51.20 / hr	Medicine GR (II)(E)	
2-7-02	97546WH	$307.20	$0.00	No EOB	$51.20 /hr	Medicine GR (II)(E)	
2-11-02	97750FC	$200.00	$0.00	M	$100.00 /hr	Medicine GR (I)(E)(2) Section 413.011(b)	

2-18-02 2-19-02 2-20-02 2-21-02 2-22-02 2-25-02 2-26-02 2-27-02 2-28-02 3-1-02	97545WH	$102.40	$0.00	No EOB	$51.20 / hr	Medicine GR (II)(E)	
2-18-02 2-19-02 2-20-02 2-21-02 2-22-02 2-25-02 2-26-02 2-27-02 2-28-02 3-1-02	97546WH	$307.20	$0.00	No EOB	$51.20 /hr	Medicine GR (II)(E)	
3-8-02 3-20-02 3-28-02 4-5-02 4-10-02 4-19-02	99213	$48.00	$0.00	N, T	$48.00	Evaluation & Management GR (IV) HB2600	
3-15-02	99213MP	$48.00	$0.00	N, T	$48.00	Medicine GR (I)(B)(1)(b) HB2600	
8-19-02	99213	$48.00	$0.00	E, T	$48.00	Evaluation & Management GR (IV) HB2600	
8-12-02	99213MP	$48.00	$0.00	E, T	$48.00	Medicine GR (I)(B)(1)(b) HB2600	
10-31-02	95937-27	$408.00	$0.00	No EOB			
TOTAL							The requestor is entitled to reimbursement of **$319.75.**

This Decision is hereby issued this 12th day of November 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 1, 2003

Requester/ Respondent Address : Rosalinda Lopez
TWCC
4000 South IH-35, MS-48
Austin, Texas 78704-7491

RE:
MDR Tracking #: M5-03-1318-01
IRO Certificate #: 5242

___ 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 proposed 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 Chiropractic physician reviewer. The Chiropractic physician reviewer 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

According to the documentation presented, the claimant was working on ___ when he lifted a 60 lb pallet and felt a sharp pain in his back. The claimant first reported to the company doctor. The company doctor had x-rays taken, which revealed no fractures. On 11/13/2001 the claimant had a MRI report performed which revealed no abnormalities other than muscle spasm. He was also being referred to ___ for medication. ___ performed an IME on 12/12/2001, which stated the claimant, had a 0% impairment and was ready for full duty at work. It appears sometime in December, the claimant began care with another chiropractor. On 12/27/2001, the claimant had a FCE done which put him at a sedentary level. He was put through a work hardening program. ___ performed another IME and determined the claimant was at MMI of 5% whole person impairment. The documentation presented gave lumbosacral strain as the only diagnosis. There was no other documentation stating anything more than a strain. The daily notes submitted were very similar and showed very little improvement. The final daily note stated the claimant had pain of 7/10, which was the same at the first note I have on 12/20/2001. There appears to be no change.

Requested Service(s)

The medical necessity of the outpatient services rendered between 02/11/2002 – 09/04/2002 including office visits and work hardening.

Decision

I agree with the insurance company that the outpatient procedures performed between 02/11/2002 – 09/04/2002 were not medically necessary.

Rationale/Basis for Decision

Throughout the supplied documentation, there was not any objective test that revealed the claimant had anything more than a strain or possibly a sprain of the lumbar region. With this in mind, the conservative care he was given at first and the original work hardening program, which lasted through 02/11/2002, was an adequate amount of care. The daily notes submitted do not support the ongoing care that was given to the claimant. The subjective complaints never changed from 12/20/2001 – 05/31/2002. With the opinion of 2 independent doctors stating that the claimant was at MMI, I feel the continued care was not reasonable or medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 1st day of April 2003.