MDR Tracking Number: M5-03-1341-01

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 1-31-03.

The IRO reviewed chiropractic treatment rendered from 4-10-02 through 7-16-02 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 24, 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
7-12-02	99213	$48.00	$0.00	No EOB	$48.00	Evaluation & Management GR (IV) Rule 133.307(g)(3)	Services that were denied without an EOB will be reviewed in accordance with *Medical Fee Guideline.*
7-12-02	97010	$11.00	$0.00		$11.00	CPT Code Descriptor Rule 133.307(g)(3)	The requestor did not submit SOAP note to support service billed per MFG.

7-12-02	97112	$35.00	$0.00		$35.00	Medicine GR (I)(A)(9)(b) Rule 133.307(g)(3)	
7-12-02	97124	$28.00	$0.00		$28.00	CPT Code Descriptor Rule 133.307(g)(3)	
7-12-02	97032	$35.00	$0.00	No EOB	$35.00	CPT Code Descriptor Rule 133.307(g)(3)	The requestor did not submit SOAP note to support service billed per MFG.
TOTAL							The requestor is not entitled to reimbursement.

This Decision is hereby issued this 3rd day of November 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

August 22, 2003

Re: IRO Case # M5-03-1341-01

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 injured his lower back on ___ when he attempted to hold a fan over a manhole. He has had several medical evaluations, MRIs, ESIs, medication, physical therapy, therapeutic exercises and chiropractic treatment.

Requested Service(s)
Therapeutic procedure, office visits, data analysis, neuromuscular stim electronic, physician education services 4/10/02-7/8/02, 7/16/02

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

Rationale
The patient had received extensive chiropractic manipulations, physical therapy and therapeutic exercises without relief of symptoms or functional improvement. His pain level was initially 7/10, and it remained at this level throughout months of treatment. The treating doctor's treatment plan never changed, even though the patient was not responding to treatment. On 1/27/03 the patient stated that he was not any better after months of treatment.

The notes provided for this review are repetitive and offer little objective information that would support treatment. The patient repeatedly reports that his pain is stabbing, cutting, burning and cramping in his lower back and radiates into his legs with tingling in both feet. I question the use of therapeutic exercises such as low impact aerobics on a patient with a pain level of 7/10 along with the previously mentioned symptoms. The documentation provided failed to describe the specific exercises prescribed for the patient.

It appears from the records provided that he patient's response to treatment plateaued in a diminished condition months prior to the dates in dispute. His chronic and ongoing care did not produce any measurable objective or subjective improvement, and did not appear to be directed at progression for return to work. It definitely was not provided in the least intensive setting. It appears from the records provided that treatment was over-utilized and inappropriate. It was not reasonable or effective in relieving symptoms or improving function, and the documentation does not show that the services were necessary.

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

Sincerely,