

MDR: Tracking Number M5-03-1489-01

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 2-10-03.

The IRO reviewed chiropractic treatment rendered on 4-10-02 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 July 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	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
6-12-02 6-14-02 6-17-02 6-26-02	97545WH	\$102.40	\$0.00	F	\$51.20 / hr	Medicine GR (II)(E)	Work hardening reports support service billed per MFG, reimbursement of 4 dates X \$102.40 = \$409.60.
7-12-02	99213MP	\$48.00	\$0.00	F	\$48.00	Medicine GR (I)(B)(1)(b)	SOAP note supports billed service per MFG; reimbursement is recommended of \$48.00.
8-9-02	99455L5	\$403.00	\$0.00	F	DOP	Evaluation & Management GR (XXII)	Medical Evaluation report supports billed service per MFG, reimbursement of \$403.00 is recommended.
TOTAL							The requestor is entitled to reimbursement of <b>\$860.60</b> .

**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 4-10-02 through 8-9-02 in this dispute.

This Decision and Order is hereby issued this 20<sup>th</sup> day of November 2003.

Elizabeth Pickle  
Medical Dispute Resolution Officer  
Medical Review Division

March 31, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

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\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

**CLINICAL HISTORY**

The patient in question was injured on her job when she was moving boxes and tripped over them, falling to the floor. She was initially evaluated by a company doctor, who diagnosed a sprain/strain injury. She later went to the requestor on this case and began a conservative treatment protocol. MRI of the lumbar spine revealed a 2 mm protrusion at L2-3 which did touch and efface the thecal sac. The patient progressed into a work hardening program and there is documentation in this file for that program.

## DISPUTED SERVICES

The carrier has denied the medical necessity for chiropractic manipulation and physical medicine for the date of April 10, 2002.

### DECISION

The reviewer agrees with the prior adverse determination.

### BASIS FOR THE DECISION

The patient had extensive and exhaustive care on this case, some of which was appropriate. However, the date in question of April 10, 2002 is not documented by the requestor for the reasonableness of the care. No notes indicate why passive therapy, or even an active plan, would be reasonable at this point in time. While it is certainly possible for a patient to have an exacerbation of a condition, there is no indication that was the case on this file. I find no objective documentation that will justify the extensive testing performed on this patient. In particular, extensive nerve testing was not reasonable at this point this patient's condition. Information received using this testing would not be reasonable, as no EMG testing seems to have been performed, and EMG is the definitive test of a radiculopathy. The fact that the tests were negative has no effect on this decision, but rather that a reasonable person would not view such testing as being informational as to help this case come to a conclusion.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,