**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-04-2026.M5**

MDR Tracking Number: M5-03-1500-01

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 2-14-03.

The IRO reviewed chiropractic treatment rendered from 5-29-02 through 7-26-02 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 7-8-03, 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 |
|---|---|---|---|---|---|---|---|
| 5-22-02 | 99203 | $74.00 | $0.00 | F | $74.00 | Evaluation & Management GR (IV) | Claimant was a new patient; SOAP note supports billed service per MFG. Reimbursement of $74.00 is recommended. |
| 5-29-02<br>6-19-02 | 95851 | $36.00 | $0.00 | G | $36.00 ea | Medicine GR (I)(E)(4) | Lumbar ROM testing was not global to any service rendered on this date; therefore, the insurance carrier incorrectly denied reimbursement based upon "G". ROM testing reports support reimbursement of $36.00 X 2 dates = $72.00. |
| 6-25-02<br>7-10-02 | 97750MT | $43.00 | $0.00 | G | $43.00 / body area | Medicine GR (I)(E)(3) and (I)(D) | Muscle testing was not global to any service rendered on this date; therefore, the insurance carrier incorrectly denied reimbursement based upon "G". The requestor did not submit muscle testing reports to support fee dispute in accordance with Rule 133.307(g)(3)(B); therefore, no reimbursement is recommended. |
| TOTAL | | | | | | | The requestor is entitled to reimbursement of **$146.00.** |

## 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 5-22-02 through 7-26-02 in this dispute

This Decision is hereby issued this 25th day of November 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer

**IRO Certificate #4599**

## NOTICE OF INDEPENDENT REVIEW DECISION

June 27, 2003

**Re: IRO Case # M5-03-1500-01**

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, and who also is a Certified Strength and Conditioning Specialist. 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 low back on ___ while lifting 80 pound boxes. The patient has had chiropractic care, physical therapy, therapeutic exercises, plain film radiology, an MRI, electrodiagnostic testing and medication.

Requested Service(s)
Chiropractic treatments 5/29/02 to 7/26/02

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

Rationale

Extensive conservative treatment was provided without documented relief of the patient's symptoms. Treatment notes were voluminous, repetitive and lacking measurable and objective improvement. After four weeks of care the patient's pain scale was still 6/10 and remained so throughout the entire treatment process.

Examination on 5/24/02 showed no neurological impairment. Muscle strength was 5/5, straight leg raise was negative and gait was normal. It was also noted that range of motion was decreased with minimal pain, spasms and tenderness. This suggests a mild injury that should have responded well to chiropractic treatment in four to six weeks, but did not do so.

The documentation for CPT code 97110 lacks specific detailed exercise description and the treatment failed to relieve symptoms or improve function; it possibly could have been iatrogenic. The documentation failed to support the need for or the effectiveness of the exercise program.

The documentation failed to support the necessity of the Dynation Human Performance Test (code 97750). The test yielded very little information to aid in the treatment of the patient. The treatment program remained the same after the test.

The documentation presented for this review failed to show objective, quantifiable findings to support treatment. Treatment must be reasonable and effective in relieving symptoms or improving function, and in this case it was not.

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

Sincerely,