MDR Tracking Number: M5-03-1549-01

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 that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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. These services (97010, 97110, 97014, 99090, 99211, 99214, 99202, and E1399) from 3-1-02 through 7-31-02 were found to be medically necessary. These services (97250, 97035, 99080-73, 99213MP, 99213, and 97530) from 3-1-02 through 7-31-02 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these services charges.

The above Findings and Decision are hereby issued this 11th day of June 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

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 3-1-02 through 7-31-02 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 11th day of June 2003.

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division

DZT/dzt

June 5, 2003

NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter

RE: **MDR Tracking #: M5-03-1549-01**

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a 39 year-old male who sustained a work-related injury on ___ resulting in neck pain, left arm pain, low back pain, and numbness and tingling in his left upper extremity. MRIs of his back and left shoulder were performed and revealed suggestion of posterior disc bulging and a labrum tear in the left shoulder. EMG and nerve conduction studies were also performed and were indicated to be negative. He has been diagnosed with a mid to lower cervical disc bulge or protrusion or herniation, left upper extremity radicular symptoms and spasms. This patient has been treated with chiropractic treatment, a series of 3 epidural steroid injections in January 2003, medication, trigger point injections, and occupational/physical therapy.

Requested Services
Office visits, physical therapy, and analysis of information from 3/13/02 to 7/31/02. Additional dates of service 3/1/02, 3/8/02, 3/11/02.

Decision
The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision
The ___ chiropractor reviewer noted that this case concerns a 39 year-old male who sustained a work related injury to his back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included mid to lower cervical disc bulge or protrusion or herniation, left upper extremity radicular symptoms and spasms. The ___ chiropractor reviewer further noted that an MRI indicated a left

shoulder labrum tear. The ___ chiropractor reviewer indicated that the patient made recovery progress in the case of his left shoulder. However, the ___ chiropractor reviewer also indicated that the chiropractic records provided contain minimal clinical documentation of orthopedic testing and no indicators of neurological testing results, minimal soft tissue findings and minimal to no chiropractic findings. The ___ chiropractor reviewer also indicated that there is no sufficient evidence that supports the necessity for continued chiropractic care. The ___ chiropractor reviewer explained that the records provided do not demonstrated that the clinical condition has significantly improved with the care provided. Therefore, the ___ chiropractor consultant concluded that the office visits that included physical therapy and analysis of information on 3/1/02, 3/8/02,3/11/02 and from 3/13/02 through 7/31/02 were medically necessary to treat this patient's condition. The ___ chiropractor consultant explained these services would include CPT codes 97010, 97110, 97014, 99090, 99111, 99214, 99202 and E1399. However, the ___ chiropractor consultant concluded that all chiropractic office visits and chiropractic treatments rendered on 3/1/02, 3/8/02,3/11/02 and from 3/13/02 through 7/31/02 were not medically necessary to treat this patient's condition. The ___ chiropractor consultant explained that these services would include CPT codes 97250, 97035, 99080-73, 99213MP, 99213 and 97530.

Sincerely,