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

SOAH DOCKET NO. 453-04-2733.M5

MDR Tracking Number: M5-03-1554-01

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 2-18-03.

The IRO reviewed chiropractic treatment rendered from 7-12-02 to 9-6-02 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 18, 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)	Amount Due	Rationale
7-19-02 8-9-02 8-22-02	99213	$48.00	$21.60	C	$48.00	$26.40 X3 = $79.20	The disputed services were denied based upon "C – Paid in accordance with affordable PPO." The requestor's representative, ___ stated on 12-2-03, that they do not have a
7-19-02 8-9-02 8-22-02	97032	$23.00	$9.90	C	$22.00	$12.10 X3 = $36.30	
8-9-02 8-22-02	97139	$35.00	$15.75	C	$35.00	$19.25 X2 = $38.50	

8-9-02 8-22-02	97110	$35.00	$15.75	C	$35.00	$19.25 X2 = $38.50	contract with ___ on this patient; therefore, the insurance carrier incorrectly reduced reimbursement.
TOTAL							The requestor is entitled to reimbursement of **$192.50.**

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 7-12-02 through 9-6-02 in this dispute.

This Order is hereby issued this 19th day of December 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

May 9, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-1554-01
IRO Certificate #: IRO 4326

___ 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 rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional 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

This patient sustained an injury to his lower back during a motor vehicle accident on ___. He has been treated by a chiropractor for therapy. The patient also had a pain management consult which involved trigger point injections to five sites in the gluteal region and two lumbar epidural injections with mild, temporary relief. An MRI done on 12/18/01 revealed small disc herniation at L5-S1.

Requested Service(s)

Chiropractic treatments rendered from 07/12/02 through 09/06/02

Decision

It is determined that the chiropractic treatments rendered from 07/12/02 through 09/06/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The documentation does not support ongoing chiropractic care from 07/12/02 through 09/06/02. Ranges of motion and other objective elements were measured on the initial visit. These revealed normal cervical ranges and 85-95% of normal lumbar ranges. It is not evident that further objective data was measured during the course of care to determine progress of therapy. Due to the lack of significant range of motion decreases it would not be clinically expected that this patient would need a long course of conservative care. In addition, he has long since passed the expected natural history for this particular condition.

Therefore, it is determined that the chiropractic treatments rendered from 07/12/02 through 09/06/02 were not medically necessary.

Sincerely,