MDR Tracking Number: M5-03-1670-01

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 3-10-03.

The IRO reviewed chiropractic treatment rendered from 3-11-02 to 12-10-02 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 May 16, 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.

Neither party submitted EOBs to support services identified as “No EOB”; therefore, they will be reviewed in accordance with *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12/10/02	64550	$101.00	$0.00	No EOB	$101.00	Rule 133.307(g)(3)(B)	The requestor did not submit medical records to support fee dispute in accordance with Rule 133.307(g)(3)(B); therefore, no reimbursement is recommended.
TOTAL							The requestor is not entitled to reimbursement.

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

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

May 14, 2003

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

MDR Tracking #: M5 03 1670 01
IRO #: 5251

___ 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

This patient was injured on her job when she was lifting heavy plywood and suffered an onset of pain in the neck, which was eventually diagnosed as a herniated disc. MRI did confirm that the patient had disc herniations from C3/4 through C6/7 and a left sided herniation at C7/T1. There was an EMG performed by ___ in October of 2000, which was negative from the reports seen. Treatment rendered by ___consisted of chiropractic manipulations, passive modalities and some rehabilitation. ___ position statement indicates that a myelogram had been requested as a precursor to surgery, but the carrier denied the care.

Multiple peer reviews were performed on this case. The first, by ___ recommended no further chiropractic treatment beyond December 12, 2000. A review by ___ dated May 23, 2002 indicated that further treatment was unnecessary. A review by ___ on October 8, 2002 agreed with ___ assessment. ___ performed yet another file review on January 6, 2003 and discussed the CPT code 64550, neurostimulator.

This patient was found to be at MMI as of December 4, 2002 with 5% impairment by designated doctor ___.

DISPUTED SERVICES

The carrier has denied the medical necessity of chiropractic and physical medicine from March 11, 2002 through December 10, 2002.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The treating doctor on this case continued for a very extensive period of time with manipulation and passive treatment, to include muscle stimulation, with no indication that the overall condition of the patient was getting better. The treatment rendered should fit the condition of the patient and in this case, it certainly seems the condition of the patient was not improved nor aided by the care. While there are certainly times when the patient felt better after the treatment, the overall condition of the patient was static and stable. As there was no reason to believe this patient would improve with that care I would have to believe that the care is not demonstrated to be reasonable and necessary.

___ 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,