THIS MDR TRACKING NO. WAS WITHDRAWN.
THE AMENDED MDR TRACKING NO. IS M5-04-2230-01

MDR Tracking Number: M5-03-1709-01

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 March 14, 2003. On February 11, 2004 requestor withdrew 72050-WP and 95851 for date of service 07-03-02.

The IRO reviewed chiropractic treatment rendered from 05-17-02 through 10-22-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity chiropractic treatment. 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 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)	Reference	Rationale
05/17/02	95851	$36.00	0.00	G	$36.00	MFG MGR (I)(E)(4)	Range of motion (95851) is not considered global to any other service billed on this date. Recommended Reimbursement $36.00
	97750 MT (4 units)	$172.00	0.00	G	$43.00/unit	MFG MGR (I)(E)(3)	Muscle testing is not global to any other service billed on this date. Recommended Reimbursement $172.00

06/04/02	97750 MT (5 units)	$215.00	0.00	G	$43.00/unit	MFG MGR (I)(E)(3)	Muscle testing is not global to any other service billed on this date. Recommended Reimbursement $215.00
06/28/02	97750 MT	$129.00	0.00	G	$43.00/unit	MFG MGR (I)(E)(3)	Muscle testing is not global to any other service billed on this date. Recommended Reimbursement $129.00
07/03/02	95851	$40.00	0.00	G	$36.00	MFG MGR (I)(E)(4)	Range of motion (95851) is not global to any other service billed on this date Recommended Reimbursement $36.00
	95851	$40.00	0.00	G	$36.00	MFG MGR (I)(E)(4)	Range of motion (95851) is not global to any other service billed on this date. Recommended reimbursement $36.00
	97750 MT (6 units)	$258.00	0.00	G	$43.00/unit	MFG MGR (I)(E)(3)	Muscle testing is not global to any other service billed on this date. Recommended Reimbursement $258.00
08/22/02	99080-73	$15.00	0.00	F	Per 129.5	Rule 129.5	Work Status report was not submitted unable to confirm service rendered therefore, reimbursement is not recommended.
10/18/02	99080-73	$15.00	0.00	F	Per 129.5	Rule 129.5	Work Status report was not submitted unable to confirm service rendered therefore, reimbursement is not recommended.
	95851	$40.00	0.00	G	$36.00	MFG MGR (I)(E)(4)	Range of motion (95851) is not global to any other service billed on this date. Recommended Reimbursement $36.00
	95851	$40.00	0.00	G	$36.00	MFG MGR (I)(E)(4)	Range of motion (95851) is not global to any other service billed on this date. Recommended Reimbursement $36.00
	95851	$40.00	0.00	G	$36.00	MFG MGR (I)(E)(4)	Range of motion (95851 is not global to any other service billed on this date. Recommended Reimbursement $36.00
	97750 MT (6	$258.00	0.00	G	$43.00/unit	MFG MGR (I)(E)(3)	Muscle testing is not global to any other service

	units)						billed on this date. Recommended Reimbursement $258.00
TOTAL		$1438.00					The requestor is entitled to reimbursement of **$**1248.00

This Decision is hereby issued this 13th day of February 2003.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

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 05-17-02 through 10-22-02 in this dispute.

This Order is hereby issued this 13th day of February 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Amended Letter
Note: Requested Service(s)

June 5, 2003

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

RE: MDR Tracking #: M5-03-1709-01
IRO Certificate #: IRO4326

___ 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 when he was climbing out of his truck, slipped, and fell on ___. His greatest pain was in the lower back with some numbness into the right buttock. He underwent a series of lumbar steroid injections with good relief but temporary. An MRI done on 07/26/02 failed to show any significant nerve root impingement.

Requested Service(s)
Chiropractic treatments rendered from 05/20/02 through 10/22/02

Decision
It is determined that the chiropractic treatments rendered from 05/20/02 through 10/22/02 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision
The medical records reviewed showed continued improvement in the patient's functional abilities. Functional testing was performed at appropriate intervals to record the effect of applied therapeutics. The provider implemented controlled trials of therapy with the imposed response monitored and the treatment algorithm modified accordingly. Testing revealed a continued gain in physical capacity and active range of motion in the cervical, lumbar, and thoracic spine.

This patient's response to the intradiscal electrothermal therapy (IDET) was not unusual. Most patients that are selected for IDET do extremely well within eight to ten weeks of post-IDET rehabilitation in conjunction with an aggressive home rehabilitation program. These responses can be altered significantly if overweight and not physically conditioned. The vital element to managing a post surgical patient is the application of functional testing to determine if the imposed therapies are of benefit to the patient. Functional data gathered by the provider outlines treatment goals and current levels of functioning well. herefore, it is determined that the chiropractic treatments rendered from 05/20/02 through 10/22/02 were medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- *Clinical practice guidelines for chronic, non-malignant pain syndrome patients II: An evidence-based approach.* J Back Musculoskeletal Rehabil 1999 Jan 1; 13; 47-58.

- *Overview of implementation of outcome assessment case management in the clinical practice.* Washington State Chiropractic Association; 2001. P54.

Sincerely,