

MDR Tracking Number: M5-03-1721-01

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 total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare; therefore, the **requestor did not prevail** in the IRO decision. 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 the only issue** to be resolved. The joint mobilization and myofascial release from 5-16-02 through 5-30-02 were found to be medically necessary. The office visits, therapeutic procedures, manual traction, and nerve conduction study from 4-18-02 through 5-30-02 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these services charges.

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 4-18-02 through 5-30-02 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 23rd day of June 2003.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

DZT/dzt

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

June 17, 2003

**Re: IRO Case # M5-02-1721**

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 and right foot on \_\_\_ as he was carrying a refrigerator down stairs and fell. He saw a chiropractor for treatment and rehabilitation.

Requested Service(s)

Chiropractic treatment 4/18/02 – 5/30/02.

Decision

I disagree with the carrier's decision to deny joint mobilization treatments ( code 97265) and myofascial release treatments (code 97250)

I agree with the carrier's decision to deny all of the other the requested treatment.

Rationale

The documentation presented for this review fails to support the necessity of office/outpatient visit, est (99213) as it lacks objective or measurable findings that are necessary for each date. Therapeutic exercises (97110) were properly denied, as the documentation presented fails to support the necessity of such intensive therapy. The documentation presented fails to show what types of exercises were used, and a home-based exercise program would have been appropriate and should have produced excellent results. Joint mobilization and myofascial release were the only modalities rendered that would be necessary and beneficial to the patient. Manual traction is necessary, but it is used in conjunction joint mobilization, not as a separate treatment.

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

Sincerely,

---