MDR Tracking Number: M5-03-1742-01

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 3-24-03.

The IRO reviewed chiropractic treatment and physical therapy services rendered from 6-12-02 through 7-17-02 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. 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On May 27, 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:

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**
6/12/02	99205	$160.00	$0.00	N	$137.00	Evaluation & Management GR (VI)(A)	Office Visit report documents billed service per MFG, reimbursement is recommended of $137.00.
6/28/02	97110 (6)	$210.00	$0.00	No EOB	$35.00/ 15 min	Medicine GR (I)(A)(9)(b)	Therapy notes supports service billed per MFG, reimbursement of $210.00 is recommended.
TOTAL							The requestor is entitled to reimbursement of **$347.00.**

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 6-12-02 through 7-17-02 in this dispute.

This Decision and Order is hereby issued this 30th day of 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

May 22, 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 #: M5-03-1742-01
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 reports having a sudden onset of low back pain while performing her normal work duties as a waitress on ___. She saw a chiropractor and was diagnoses with lumbar sprain/strain, lumbar facet syndrome, and myofascial syndrome and began various therapeutic modalities with this provider.

Requested Service(s)
The office visits, joint mobilization, myofascial release, group therapeutic procedures, and therapeutic exercises from 06/12/02 through 07/17/02

Decision
It is determined that the office visits, joint mobilization, myofascial release, group therapeutic procedures, and therapeutic exercises from 06/12/02 through 07/17/02 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision
This patient was initially diagnosed with lumbar strain/sprain, lumbar facet syndrome, and myofascial pain syndrome. She began a course of passive/active care with the chiropractor, being treated on eight occasions over a period of five weeks. Haldeman et al indicate that it is beneficial to proceed to the rehabilitation phase of care as rapidly as possible to minimize dependence on passive forms of treatment/care and reaching the rehabilitation phase as rapidly as possible and minimizing dependence on passive treatment usually leads to the optimum result. Reference: Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993.

The use of myofascial release in the treatment of the patient was medically necessary as manipulation is standard in the management of spinal strains/sprains and other spinal disorders. Spinal strains/sprains are self-limiting conditions that typically resolve with or without care with in a two month time period. The maximum therapeutic benefit for spinal manipulation is noted in the first 2 to 3 weeks of care.

The overall duration of care was within established parameters for the case duration. Haldeman et al indicated that most cases resolve well within 6 weeks of intervention, which is consistent with the expectations from natural history *(Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaitherburg, Maryland, 1993, p. 121).* Therefore, the office visits, joint mobilization, myofascial release, group therapeutic procedures, and therapeutic exercises from 06/12/02 through 07/17/02 were medically necessary.

Sincerely,