MDR Tracking Number: M5-03-2005-01

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 04-11-03.

The IRO reviewed mechanical traction, joint mobilization, manual traction, and electrical stimulation rendered from 04-16-02 through 04-25-02 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 for mechanical traction, joint mobilization, manual traction, and electrical stimulation. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 07-09-03, 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
05-02-02	97032	$22.00	0.00	T	$22.00		Carrier denied as "T- outside of treatment guidelines." The treatment guidelines were abolished by statute effective 01-01-02; therefore, this review will be per the MFG. Office note dated 05-02-02 supports service rendered. Recommended reimbursement $22.00

	97012	$10.00	0.00	T	$10.00		Carrier denied as "T- outside of treatment guidelines." The treatment guidelines were abolished by statute effective 01-01-02; therefore, this review will be per the MFG. Office note do not support service rendered. Reimbursement is not recommended
05-15-02	97265	$43.00	0.00	T	$43.00		Carrier denied as "T- outside of treatment guidelines." The treatment guidelines were abolished by statute effective 01-01-02; therefore, this review will be per the MFG. Office note dated 05-15-02 supports service rendered. Recommended reimbursement $43.00
	97032	$66.00	0.00	T	$22.00		Carrier denied as "T- outside of treatment guidelines." The treatment guidelines were abolished by statute effective 01-01-02; therefore, this review will be per the MFG. Office note dated 05-02-02 supports service rendered. Recommended reimbursement $66.00 ($22.00 for 3 units)
	97022	$60.00	0.00	T	$20.00		Carrier denied as "T- outside of treatment guidelines." The treatment guidelines were abolished by statute effective 01-01-02; therefore, this review will be per the MFG. Office note dated 05-02-02 supports service rendered. Recommended reimbursement $60.00 ($20.00 for 3 units)
TOTAL		$201.00					The requestor is entitled to reimbursement of **$191.00**

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 05-02-02 through 05-15-02 in this dispute.

This Decision is hereby issued this 29th day of April 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

July 2, 2003 **REVISED**

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

MDR Tracking #: M5 03 2005 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

___ was injured on her job when she was lifting a box from a pallet and several other boxes on the pallet fell on top of her, causing her to be knocked to the floor. She reported pain in her neck and low back following the injury. She began treatment shortly afterward under the care of ___ at ___. She has been referred to a medical provider who prescribed medications and ESI therapy to the neck. No MRI is included to determine the reasoning behind ESI therapy nor is there any EMG result included in the package.

DISPUTED SERVICES

The carrier has denied the medical necessity of office joint mobilization, manual traction, mechanical traction, electrical stimulation and office visits with manipulations from April 16, 2002 through April 25, 2002.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

There is no doubt that this patient suffered a serious injury to the neck region. The care in question, however, is not reasonable in that there is no documentation as to the necessity of the care by the treating doctor. In looking at the notes, there is very little in the way to explain why such extensive treatment with little discernable result would continue at this point. While I have no doubt that the treating doctor felt he was getting the patient well enough to return to work, I also have no documentation to indicate that the ongoing care resulted in such a return to work and I also see nothing to indicate that this injury should have still been treated a full ___ years after injury. Accordingly, I am unable to validate the medical necessity of the care rendered in this case.

___ 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,