MDR Tracking Number: M5-03-2199-01

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 05-05-03.

The IRO reviewed manipulations rendered from 12-05-02 through 12-28-01 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 manipulations rendered after 02-15-03. .

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for manipulations rendered through 02-15-03. Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees ($945.00). Therefore, upon receipt of this Order and in accordance with §133.308(q)(9) Use §133.308(r)(9) for request filed on or after 1-1-03, the Commission hereby orders the respondent and non-prevailing party to refund the requestor $460.00 for 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 07-29-03, 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. Relevant information was not submitted by the requestor in accordance with Rule 133.309 (g)(3) to confirm delivery of service for the fee component in this dispute. Therefore reimbursement is not recommended

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 12-05-02 through 02-15-03 in this dispute.

This Decision is hereby issued this 17th day of March 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

July 24, 2003

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

MDR Tracking #: M5-03-2199-01
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.

The independent review was performed by a matched peer with the treating doctor. 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

On 7/20/02, ___ was working as a fireman/paramedic for the city of ___ when he suffered a work-related injury that as a result of lifting a patient from a stretcher. He felt low back pain and went to the emergency room where x-rays were taken. He was prescribed medications for his lumbar complaint. On 10/2/02 he was referred for an MRI of the low back. The scan revealed a 3-4 mm disc protrusion at L5/S1 that did displace the epidural fat pad, and a disc bulge was noted at L4/5.

The patient was referred for an EMG/NCV on 11/1/02 that revealed a mild left S1 radiculopathy. The patient also underwent an IME on 12/3/02 that stated the patient may never be able to work as an EMS/paramedic again, and that chiropractic care was no longer reasonable or necessary.

The documentation presented for review shows the carrier has denied payment of manipulation services dated 12/5/02 through 4/4/03. The insurance company has denied payment of manipulation due to unnecessary treatment (with and without a peer review). The documentation also states there was a peer review performed on 4/2/03 by the carrier.

DISPUTED SERVICES

Under dispute is the medical necessity of regional manipulation provided from 12/5/02 through 4/4/03.

DECISION

The reviewer both agrees and disagrees with the prior adverse determination.

The reviewer finds that there was medical necessity for the treatment rendered through February 15, 2003 however, the reviewer did not find medical necessary for chiropractic manipulation beyond that date.

BASIS FOR THE DECISION

The reviewer finds that there was medical necessity for the treatment rendered through February 15, 2003. The treatment provided after 2/15/03 did not reflect enough symptomatic relief to warrant continued care in the form of chiropractic manipulation.

The rationale for determining treatment was deducted from the obvious objective and subjective results from the treatment provided. The determination falls within the Mercy Fee Guidelines, Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters, and is well within the mainstream of the medical community.

___ 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,