MDR Tracking Number: M5-03-2422-01

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 requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(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 the only issue** to be resolved. The office visit on 1/17/03, therapeutic procedures and massage therapy rendered twice a week between 1/17/03 and 2/5/03, were found to be medically necessary. The remaining office visits and treatments were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the office visit on 1/17/03, therapeutic procedure and massage therapy 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 1/17/03 through 2/5/03 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 25th day of July 2003
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Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division
CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION - REVISION

Date: July 24, 2003

RE: MDR Tracking #: M5-03-2422-01
IRO Certificate #: **5242**

___ 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 proposed 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 Chiropractic physician reviewer. The Chiropractic physician reviewer 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
According to the documentation supplied, it appears that the claimant was performing her normal activities at work and was assisting a person move, when they both fell to the ground. She reported shooting pain and reported to a ___ for evaluation and treatment. After minimal treatment she changed doctors to ___, but felt her care was being rushed, and changed doctors again, to ___. She began chiropractic care with ___ on 10/10/2002. A MRI was performed on 11/20/2002 which revealed a 1 mm bulge at L3-4, a 1–2 mm disc bulge at L4-5 and at L5-S1 with no effacing and with adequate disc height. The claimant was referred to ___ for medications on 12/16/2002. The claimant was treated approximately 82 times with passive and active modalities. An exam was performed by ___ who felt the claimant was not at maximum medical improvement on 02/12/2003. The documentation ends here.

Requested Service(s)
Please review and address the medical necessity of the outpatient services including office visits, ultrasound, massage therapy, therapeutic procedures, manual traction, and myofascial release rendered 01/17/2003 – 02/05/2003.

Decision
I agree with the insurance company that the daily office visits, ultrasound, myofascial release, manual traction were not medically necessary from 01/17/2003 – 02/05/2003. I disagree with the insurance provider and agree with the treating doctor that the therapeutic procedures and massage therapy rendered twice a week between 01/17/2003 – 02/05/2003 and the office visit on 01/17/2003 were medically necessary.

Rationale/Basis for Decision

The claimant underwent chiropractic therapy for approximately 9 weeks when the dates of service came into question. The initial 9 weeks is a normal protocol for this form of diagnosis. The MRI performed did not show any nerve pressure on the effacing nerves, which would indicate that a typical treatment program would be warranted. Since the claimant was not at maximum medical improvement on 02/12/2003, it would indicate that the claimant still needed conservative care to return her to her normal job duties. Past an 8-week timeframe, it would be medically necessary to have the claimant on an active treatment regimen. Passive modalities have not shown effectiveness beyond this time.Therefore, the therapeutic exercises are considered appropriate and necessary for the treatment of the claimant's symptoms.The documentation does not warrant the daily office visits that were billed. The claimant was being evaluated through her continual chiropractic therapy. Since the claimant was several months post injury, it would also be necessary to reduce the frequency of care the she received. Bi-weekly therapy sessions would be considered adequate and necessary per the objective documentation supplied.