MDR Tracking Number: M5-03-2454-01

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 06-02-03.

The IRO reviewed office visits, myofasical release, joint mobilization, therapeutic procedures, and manual traction rendered from 06-04-02 through 07-26-02 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 office visits, myofasical release, joint mobilization, therapeutic procedures, and manual traction. 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 08-15-03, 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** |
|---|---|---|---|---|---|---|---|
| 06-05-02<br>06-21-02 | 97750<br>MT<br>(2 units) | $43.00 | 0.00 | G | $43.00 | Rule 133.307(g)(3)(A-F) | Muscle testing is not global to an office visit. Recommended reimbursement $86.00 ($43 per unit) |
| 06-27-02 | 95851 | $36.00 | 0.00 | G | $36.00 | MFG MGR (I)(11)(C)(4) | Per MFG MGR (I)(11)(C)(4) range of motion testing is not global to an office visit. Recommended reimbursement $36.00 |
| TOTAL | | $122.00 | | | | | The requestor is entitled to reimbursement of **$** 122.00 |

**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 06-05-02, 06-21-02, and 06-27-02 in this dispute.

This Decision is hereby issued this 13th day of February 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

August 12, 2003

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

MDR Tracking #: M5 03 2454 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

The patient in question injured his low back and right foot when he was struck by a refrigerator. MRI of the lumbar spine revealed a bulge which came into contact with the thecal sac. He was treated with chiropractic, active and passive therapy by the treating clinic on his case. Ranges of motion were normal on the testing that was performed, but the treating doctor indicated that there was weakness in the musculature.

DISPUTED SERVICES

The carrier has denied the medical necessity of office visits, myofascial release, joint mobilization, therapeutic procedures and manual traction from June 4, 2002 through July 26, 2002.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The care rendered on this patient is poorly documented. The office notes received are boilerplate in nature and repetitive. No indication of progress is given and there is no reasonable rationale given for ongoing treatment on this case. It is the responsibility of the treating provider to document the medical necessity of ongoing treatment in a manner that would explain the medical necessity, not just the procedures that were performed. As a result, the reviewer finds that the care was documented appropriately that would allow for the finding of this care being reasonable.

___ 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,