

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION:

SOAH DOCKET NO. 453-04-5710.M5

MDR Tracking Number: M5-03-2661-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 6-23-03.

The IRO reviewed office visits, therapeutic procedures, and myofascial release from 4-8-03 through 5-21-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of 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.

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

On 8-7-03, 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.

CPT codes 99213-MP and 99455-RP on date of service 5-30-03 – neither party submitted an EOB. Respondent's response indicates they never received a bill for date of service 5-30-03. The requestor's initial position statement indicates that all dates of service prior to 5-30-03 were submitted for reconsideration but not the 5-30-03 date of service. Per Rule 133.308 (f) (3), there is no convincing evidence of the carrier's receipt of the request for reconsideration for date of service 5-30-03; therefore, no review will be made on this date of service.

This Decision is hereby issued this 26th day of March 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

August 5, 2003

Re: MDR #: M5-03-2661-01
IRO Certificate No.: 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Certified in Chiropractic Medicine.

Clinical History:

This male claimant was injured on his job on ____. He was seen by a Chiropractor on 01/29/03. Impressions given at that time were rotator cuff sprain/strain, bicipital tenosynovitis, and cervical intervertebral disc displacement without myelopathy. An extensive conservative treatment plan was implemented that included chiropractic care, passive therapies, and active therapies.

MRI's of his cervicals and right shoulder revealed a focal 3.0 mm disc protrusion at the right anterior subarachnoid space at the C6-C7 level, with no impingement of the nerve noted. The shoulder MRI displayed a small partial tear at the supraspinatus and infraspinatus tendon head. Needle EMG indicated a right dorsal scapular nerve lesion.

An evaluation by an M.D. confirmed the diagnosis. He noted that the patient's sensory responses were normal, and axial compressing of the cervical spine was not aggravating. The patient received chiropractic treatment two to three times a week from 01/29/03/ through 05/23/03.

Disputed Services:

Office visits, therapeutic procedures, and myofascial release on 04/08/03 through 05/21/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the procedures and office visits in question were not medically necessary in this case.

Rationale:

The patient had reached a significant reduction in pain and symptoms by 04/02/03. Chiropractic guidelines indicate that a physician should generally use two-week trials of care to determine a patient's progress and necessary treatment. The concept is to avoid over treatment that might lead to illness conviction, disability mindset, and/or chronic complaints of pain.

The Mootz Care Plans indicate that the length of treatment in this case was not unreasonable. However, no trial reductions in care were undertaken to determine the actual progress and/or stability of the patient. The guides also indicate that strengthening exercises can be performed at home, which did not occur in this case. The treatment rendered appears to be beyond the standards of care as indicated in both Mercy and Mootz. These treatments are, therefore, not considered to have been medically necessary.

According to Texas Labor Code 408:021(a), an employee is entitled to the care reasonably required in association with their injury and the treatment thereof. If the patient's condition is not stable, the care to maintain and promote healing is medically necessary.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,