

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 June 23, 2003.

The IRO reviewed office visits, muscle testing, myofascial release, joint mobilization, range of motion, manual traction, therapeutic procedures rendered on 9/3/02 through 9/10/02 denied based upon "V".

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.

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 August 18, 2003, 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.

Both the requestor and the respondent failed to submit copies of EOBs. Therefore the charges listed below will be reviewed according to the Medical Fee Guideline.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
9/9/02	97265	\$43.00	\$0.00	No EOB	\$43.00	<u>MFG, Medicine Ground Rule</u> (I)(A)(9)(c), (I)(A)(10)(a)  Rule 133.307 (g)(3)	Review of the office note does not support delivery of service. The requestor, is therefore, not entitled to reimbursement of the disputed charges.
	97250	\$43.00	\$0.00	No EOB	\$43.00	<u>MFG, Medicine Ground Rule</u> (I)(A)(9)(c), (I)(A)(10)(a)  Rule 133.307 (g)(3)	Review of the office note does not support delivery of service. The requestor, is therefore, not entitled to reimbursement of the disputed charges.
	97122	\$35.00	\$0.00	No EOB	\$35.00	<u>MFG, Medicine Ground Rule</u> (I)(A)(9)(b), (I)(A)(10)(a)	Review of the office note does not support delivery of service. The requestor, is therefore, not entitled to

						Rule 133.307 (g)(3)	reimbursement of the disputed charges.
	95999	\$128.00	\$0.00	No EOB	DOP	CPT code descriptor Rule 133.307 (g)(3)	Review of the office note does not support delivery of service. The requestor, is therefore, not entitled to reimbursement of the disputed charges.
9/10/02	97265	\$43.00	\$0.00	No EOB	\$43.00	<u>MFG, Medicine</u> <u>Ground Rule</u> (I)(A)(9)(c), (I)(A)(10)(a) Rule 133.307 (g)(3)	Review of the office note does not support delivery of service. The requestor, is therefore, not entitled to reimbursement of the disputed charges.
	97250	\$43.00	\$0.00	No EOB	\$43.00	<u>MFG, Medicine</u> <u>Ground Rule</u> (I)(A)(9)(c), (I)(A)(10)(a) Rule 133.307 (g)(3)	Review of the office note does not support delivery of service. The requestor, is therefore, not entitled to reimbursement of the disputed charges.
	97122	\$35.00	\$0.00	No EOB	\$35.00	<u>MFG, Medicine</u> <u>Ground Rule</u> (I)(A)(9)(b), (I)(A)(10)(a) Rule 133.307 (g)(3)	Review of the office note does not support delivery of service. The requestor, is therefore, not entitled to reimbursement of the disputed charges.
TOTAL		\$370.00	\$0.00		\$242.00		The requestor is not entitled to reimbursement of the dispute charged.

This Decision is hereby issued this 15<sup>th</sup> day of January 2004.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division

MQO/mqo

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

July 29, 2003

**Re: IRO Case # M5-03-2669-01**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 39-year-old female who fell over a "rollout" and injured her low back on \_\_\_. Over the next several weeks, she developed excruciating low back pain, initially radiating down the left leg. An MRI of the lumbar spine on 12/12/01 revealed a large central herniated disk at L5-S1.

Requested Service(s)

Office visits, muscle testing, myofascial release, joint mobilization, range of motion, manual traction, therapeutic procedures 9/3/02-9/10/02

Decision

I agree with the carrier's decision to deny the requested treatment.

Rationale

Based on the information provided for this review, I agree with the denial of the requested services. Due to the fact that MMI had been reached on 8/20/02 and no evidence of exacerbation was presented, it is my opinion, based on *Occupational Health Guidelines for the Management of Low Back Pain at Work*, and on my training and experience, that the requested services exceeded reasonable standards of care to achieve resolution of the patient's condition.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,