

MDR Tracking Number: M5-02-2421-01

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, the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore, the **requestor did not prevail** in the IRO decision. 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.

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 chiropractic treatment (which included, nine (9) office visit with joint mobilization and one therapeutic exercise) was found to be medically necessary. The respondent raised no other reasons for denying reimbursement charges for the chiropractic treatment.

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 through in this dispute and IRO fee.

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 21st day of November 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

September 30, 2002

Re: Medical Dispute Resolution
MDR #: M5.02.2421.01
IRO Certificate No.: IRO 5055

Dear

___ 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. A physician who is a doctor of Chiropractic medicine reviewed this case.

The physician reviewer PARTIALLY AGREES with the determination of the insurance carrier in this case. The reviewer is of the opinion that unusual travel on 08.24.01 and 09.25.01 **WAS NOT MEDICALLY NECESSARY; Myo-fascial release and traction from 09.18.01 through 10.31.01 WERE NOT MEDICALLY NECESSARY; work hardening from 11.05.01 through 12.13.01 WAS NOT medically necessary. However, joint mobilization and therapeutic exercises from 09.18.01 through 10.31.01 WERE MEDICALLY NECESSARY; and, nine (9) office visits from 08.24.01 through 01.18.02 WERE 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.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning MDR #M5-02-2421-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. TWCC IRO Assignment dated July 19, 2001, one page.
2. TWCC-60 Medical Dispute Resolution Request/Response, 4 pages.
3. TWCC-60 Table of Disputed Services, 5 pages.
4. Alternate TWCC-62, Explanation of Benefits, 15 pages.
5. TWCC Hearing Decision dated January 28, 2002, 5 pages.
6. Carrier RME examinations (x2), 8 pages.
7. Carrier peer review reports, 6 pages.
8. Treating physician (chiropractor) report explaining rationale for treatment, 3 pages.
9. ___ Report, 3 pages.
10. Treating Physician SOAP notes, 84 pages.
11. Initial Psychological Assessment, dated 12/05/01, 3 pages.
12. FCE examinations (x3), 72 pages.

B. BRIEF CLINICAL HISTORY:

This patient reportedly was injured in a work-related accident on ___ in which his right ring finger was crushed (amputated?) in a machine. He was seen at ___ Hospital and underwent an open reduction internal fixation of the right fourth finger fracture with repair on the extensor tendons on 3/08/01. A second surgery was performed on May 19, 2001. On 6/28/01, a third surgical procedure was performed, a reconstruction of the extensor tendon with apparatus using a free palmaris tendon graft. The new treating physician (a chiropractor) began treating on August 20, 2001, which included office visits (99213), joint mobilization (97265), myofascial release (97250), traction (97122), and therapeutic exercise (x4) (97110). On or about 11/05/01, the patient was advanced to a work hardening program (97545-WH and 97546-WH) which lasted until 12/13/01.

C. DISPUTED SERVICES:

DOS 8/24/01 through 1/18/02, Office Visit (99213) (x12).
DOS 8/24/01 through 9/25/01, Unusual Travel (99082), (x2).
DOS 9/18/01 through 10/31/01, (97265) Joint mobilization (x3); (97250) Myofascial release (x3); (97122) Traction (x3); and (97110) Therapeutic exercise (x3) (x4 units each visit).
DOS 11/05/01 through 12/13/01, Work Hardening (x27) (97545-WH and 97546-WH) (multiple units).
DOS 12/14/01, FCE (97750-FC) (x1).

D. DECISION:

I PARTIALLY AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

DOS 8/24/01 through 9/25/01, Unusual Travel (99082), DOP required.

No documentation available for review.

*Independent Reviewer determines that 99082 was **NOT** medically necessary.*

DOS 9/18/01 through 10/31/01, (97265) Joint mobilization (x3); (97250) Myofascial release (x3); (97122) Traction (x3); and (97110) Therapeutic exercise (x3) (x4 units each visit).

Apparently, the insurance carrier based its denial on peer review of November 15, 2001. The peer review did recommend some postoperative therapy. The records reveal approximately 35 office visits over an 11-week period prior to work hardening. Most office visits consisted of (97265) Joint mobilization, (97250) Myofascial release, (97122) Traction, and (97110) Therapeutic exercise (x4 units each visit). From the records reviewed during this time period, the carrier denied eight (8) office visits (99213) and the physical medicine procedures listed above. I would expect each office visit to consist of one (1) unit of therapeutic exercise and joint mobilization. Myofascial release and traction would not be expected to provide any additional therapeutic benefit. Documentation does not support the need for myofascial release and traction.

Independent Reviewer determines (97265) Joint mobilization (x3) to be medically necessary.

Independent Reviewer determines therapeutic exercise (x3) (x1 unit each visit) to be medically necessary.

*Independent Reviewer determines (97250) Myofascial release (x3) **NOT** to be medically necessary.*

*Independent Reviewer determines (97122) Traction (x3) **NOT** to be medically necessary.*

DOS 8/24/01 through 1/18/02, Office Visit (99213) (x12).

Apparently, the insurance carrier based its denial on peer review of 11/15/01. The peer review did recommend some postoperative therapy. The records reveal approximately 35 office visits over an 11-week period prior to work hardening. From the records reviewed during this time period, the carrier denied eight (8) office visits (99213) from 8/24/01 through 11/05/01, three (3) visits in December 2001, and one visit in January 2002. I feel that the eight visits during the active treatment program are appropriate. However, I feel that only one visit was necessary in the two-week period from December 2001 to January 2002.

Independent Reviewer determines only nine (9) office visits to be medically necessary.

DOS 11/05/01 through 12/13/01, Work Hardening (x27) (97545-WH and 97546-WH) (multiple units).

Guidelines listing criteria for determining which patients may benefit from work conditioning or work hardening are not currently recognized in Texas by the chiropractic licensing board,

State associations, or practice and parameters committees. The general consensus is that candidates for work conditioning and work hardening is a judgmental call, determined by many possible variations of clinical presentations. The Texas Worker's Compensation Commission Medical Fee Guidelines of 1996 adopted its work conditioning, work hardening, outpatient medical rehabilitation and chronic pain management guidelines from The Commission of Accreditation and Rehabilitation Facilities (CARF) 1994 Standards Manual and appear to be the generally accepted guidelines.

From a document authored by Craig Liebenson entitled, *The Purpose of Spinal Rehabilitation: Integration of Passive and Active Care*: "Most third-party payors have experienced ongoing treatment for chronic musculoskeletal pain without any realistic endpoints of care. There are no objective tests from which to determine the need for appropriate care or the conclusion of it." "However, there is a sound rationale for spinal rehabilitation for chronic musculoskeletal pain. Whereas palliative measures, in particular spinal manipulation, give much needed symptomatic relief and improved activity tolerance in acute pain patients, it is exercise which is proven to be effective in chronic situations."

In a document authored by K.D. Christensen, D.C. entitled, *Physiotherapy and Rehabilitation Guidelines for the Chiropractic Profession*: "Each clinician must depend on his or her own knowledge of chiropractic and expertise in the use or modification of these materials and information. Generally, passive care is time limited, progressing to active care and patient functional recovery." "Further research appears necessary in order to obtain a consensus of the clinical guidelines of the application of specific physiotherapy rehabilitative procedures, concerning the restoration of function and prevention of disability following disease, injury, or loss of body part."

Independent Review Response - This patient had previously undergone eleven (11) weeks of therapy consisting of therapeutic exercise, joint mobilization, myofascial release techniques, and traction which failed to achieve desires and goals to promote recovery. Thus, it is doubtful that a work hardening program would produce significant results to justify the additional medical care. Additionally, a requirement for work hardening is the presence of identifying and treating the psychological barriers in recovery. Documentation fails to support the medical necessity of addressing any psychological component prior to entering a work hardening program.

*Independent Reviewer determines that work hardening was **NOT** medically necessary.*

DOS 12/14/01, FCE (97750-FC) (x1).

Independent Review Response - The clinical reasoning submitted by the provider is not felt to be medically necessary in the treatment of this patient. FCE was performed upon completion of work hardening program, which was not felt to be necessary.

*Independent Reviewer determines that this FCE was **NOT** medically necessary.*

This review utilizes treatment criteria, when possible, based on The Texas Guideline for Chiropractic Quality and Assurance and Practice Parameters.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

I certify that I have no past or present relationship with the patient and no significant past or present relationship with the attending physician. I further certify that there is no professional, familial, financial, or other affiliation, relationship, or interest with the developer or manufacturer of the principal drug, device, procedure, or other treatment being recommended for the patient whose treatment is the subject of this review. Any affiliation that I may have with this insurance carrier, or as a participating provider in this insurance carrier's network, at no time constitutes more than 10% of my gross annual income.

Date: 27 September 2002