

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

SOAH DOCKET NO.: 453-03-1905.M5

MDR Tracking Number: M5-02-2898-01

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. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees (\$2,665.00). 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.

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 (including office visits and physical therapies) was found to be medically necessary. The respondent raised no other reasons for denying reimbursement charges for the.

This Finding and Decision is hereby issued this 17th day of December 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer

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 2/4/02 through 4/5/02 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 17th day of, December 2002.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/cl

November 25, 2002

Re: Medical Dispute Resolution
MDR #: M5.02.2898.01
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. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:

This claimant was injured on the job on ____. The patient has been treated with heat modalities, electrical stimulation, neuromuscular re-education, massage therapy, group therapy, gait training, acupuncture, and various therapeutic exercises.

Disputed Services:

Office visits with manipulation, acupuncture and physical therapy from 02/04/02 through 04/05/02.

Decision:

The reviewer partially agrees with the determination of the insurance carrier. The reviewer is of the opinion that treatments **were medically necessary** as follows:

- thirty (30) office visits (99204, 99211 or 99213) for the period 02/04/02 through 04/05/02,
- seventeen (17) heat modality treatments (97010, 97035 or 97018) at one per visit for the period 02/04/02 through 03/15/02 (initial six-week period),
- seventeen (17) electrical stimulation treatments (97014) at one per visit for the period 02/04/02 through 03/15/02 (initial six-week period); and,
- fifteen (15) therapeutic exercise treatments (97110) at one per visit for the period 02/27/02 through 04/05/02 (last six weeks of treatment).

The reviewer has determined that treatments **were not medically necessary** as follows:

- neuromuscular re-education (97112),
- massage therapy (97124),
- group therapy (97150),
- gait training (97116); and,
- acupuncture (97139-AC).

Rationale for Decision:

The claimant's treating physician referred the claimant for appropriate treatment. Physical medicine procedures are considered appropriate treatment for the musculo-skeletal symptoms of pain, swelling, weakness and others. Some physical medicine modalities have similar therapeutic effects. Thus, applying multiple modalities which provide similar therapeutic effects on the same visit would provide little, if any, additional therapeutic value. The records indicate a decrease in subjective pain and decreased disability over two months of treatment.

These conclusions were taken in part from the *Texas Guidelines for Chiropractic Quality and Assurance and Practice Parameters*.

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,