

MDR Tracking Number: M5-04-0065-01

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 9-3-03.

The IRO reviewed office visits w/manipulations, physical therapy, massage therapy, electrical stimulation, aquatic therapy, acupuncture, training in activities of daily living, spirometry, electrocardiogram, whirlpool, and therapeutic procedures from 9-3-02 through 2-18-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO concluded that the office visits w/manipulations; physical therapy, massage therapy, acupuncture, and electrical stimulations from 9-3-02 through 9-24-02 were medically necessary. The IRO agreed with the previous determination that aquatic therapy, therapeutic procedures, training in activities of daily living, spirometry, electrocardiogram, and whirlpool from 9-3-02 through 2-18-03 and the office visits w/manipulations, physical therapy, massage therapy, acupuncture, and electrical stimulation after 9-24-02 were **not** medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

Per §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. The disputed dates of service 8-27-02 through 8-29-02 are untimely and ineligible for review per TWCC Rule 133.307 (d)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute. The Commission received the medical dispute on 9-3-03.

On 12-17-03, the Medical Review Division submitted a Notice to the 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 respondent's initial response included the missing EOBs; however, the response was untimely.

Services that were denied without an EOB will be reviewed per the 1996 *Medical Fee Guideline*.

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

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
11/5/02 11/6/02	97530 x 2 97110 x 2 97113 x 2 97022 x 2	\$140.00x2 \$105.00x2 \$52.00x2 \$20.00x2	\$0.00	No EOB	\$35.00 ea 15 min \$35.00 ea 15 min \$52.00 ea 15 min \$20.00	Rule 133.307(g)(3) (A-F)	Additional documentation was submitted; however, no relevant information was included to support delivery of services. No reimbursement recommended.
11/13/02	99213- MP	\$48.00	\$0.00	No EOB	\$48.00		
TOTAL		\$682.00	\$0.00				The requestor is not entitled to reimbursement.

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 Order is applicable for dates of service 9-3-02 through 9-24-02 in this dispute.

This Order is hereby issued this 12th day of February 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

December 10, 2003

Amended Decision
Note: Services and dates

MDR Tracking #: M5-04-0065-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating 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 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 this case.

Clinical History

This patient sustained a repetitive injury on ___ due to working with a computer and keyboard. He reported headache, cervical pain, and bilateral upper extremity pain. A cervical MRI dated 08/05/02 revealed central disc herniations at C3-4, C4-5, and C5-6.

Requested Service(s)

Office visits with manipulation, physical therapy, massage therapy, electrical stimulation, aquatic therapy, acupuncture, training in activities of daily living (ADLs), spirometry, electrocardiogram, whirlpool, and therapeutic procedures from 09/03/02 through 02/18/03

Decision

It is determined that the office visits with manipulation, physical therapy, massage therapy, acupuncture, and electrical stimulation from 09/03/02 through 09/24/02 were medically necessary to treat this patient's condition. However, the aquatic therapy, therapeutic procedures, training in activities of daily living (ADLs), spirometry, electrocardiogram, and whirlpool from 09/03/02 through 02/18/03 and the office visits with manipulation, physical therapy, massage therapy, acupuncture, and electrical stimulation after 09/24/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical records revealed that the patient was treated with varying combinations of spinal manipulation with electrical stimulation, spray and stretch, ultrasound, massage, traction, and acupuncture. There was no evidence in the chiropractic progress notes reviewed to indicate that the patient was treated with aquatic therapy, kinetic activities, or therapeutic procedures. As no documentation supportive of these therapies was found, they are not medically necessary.

The medical records reviewed contained self-reported pain scores for most dates of service that were reviewed. The progress notes revealed little to no appreciable change in the patient's condition as denoted by his self-reported pain level after 08/27/02.

The continued use of office visits, passive spinal manipulation, message therapy, and electrical stimulation was not medically necessary after 09/24/02. An adequate trial of care is defined as a course of two weeks each of different types of manual procedures, 4 weeks total, after which, in the absence of documented improvement, manual procedures are no longer indicated (*Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993*).

The continued use of passive physical therapy modalities and treatments (office visits with manipulation, message, acupuncture, electrical stimulation) after 09/24/02 was not medically necessary. The Philadelphia Panel indicated that for neck pain, therapeutic exercises were the only intervention with clinically important benefit. There was good agreement with this recommendation from practitioners (93%). For several interventions and indications (e.g. thermotherapy, therapeutic ultrasound, massage, electrical stimulation), there was a lack of evidence regarding efficacy (*Philadelphia Panel Evidenced-Based Guidelines on Selected Rehabilitation Interventions for Neck Pain. Phys Ther. 2001; 81:1701-1717*)

Therefore, it is determined that the office visits with manipulation, physical therapy, massage therapy, acupuncture, and electrical stimulation from 09/03/02 through 09/24/02 were medically necessary to treat this patient's condition. However, the aquatic therapy, therapeutic procedures, training in activities of daily living (ADLs), spirometry, electrocardiogram, and whirlpool from 09/03/02 through 02/18/03 and the office visits with manipulation, physical therapy, massage therapy, acupuncture, and electrical stimulation after 09/24/02 were not medically necessary.

Sincerely,