

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

SOAH DOCKET NO. 453-05-0972.M5

MDR Tracking Number: M5-04-0552-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 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 10-22-03.

Date of service 10-21-02 was submitted untimely per above referenced Rule and will not be considered in this decision.

The IRO reviewed office visit with manipulation, myofascial release, electric stimulation therapy, hot/cold pack therapy, ultrasound therapy, aquatic therapeutic exercises, mechanical traction therapy rendered from 10-22-02 through 6-27-03 that were denied based upon "U".

The IRO concluded that "I disagree with the carrier and find that the chiropractic care rendered prior to 11/19/02 was medically necessary at only 3 times per week, not 5 times per week as documented. I further disagree with the carrier and find that the active chiropractic care to include the active codes as well as the manipulation and office visit codes which were rendered for up to 6 visits over no longer than a 2 week period immediately following each epidural steroid injection were medically necessary....I agree with the insurance carrier and find that the chiropractic office visits billed at the 99213 level were not supported as medically necessary as the chiropractic documentation submitted for review indicates the 99212 code would have been more characteristic of the documentation than was the 99213 code. To repeatedly bill for a 99213 code for 80 visits through June 2003 for a well defined focused condition without apparent change in the claimant's condition is not medically necessary...the claimant had epidural steroid injections on two other dates, which are not documented. Treatment up to two weeks post-injection, with a maximum of 3X/week, would be reasonable and necessary after each injection...All other services rendered are not considered to be medically necessary."

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.

DOS	CPT CODE	Billed	MAR\$ (Maximum Allowable Reimbursement)	Medically Necessary	Not Medically Necessary
10-22-02 10-23-02 10-24-02 10-25-02 10-28-02 10-29-02 10-30-02 10-31-02 11-1-02 11-04-02 11-5-02 11-6-02 11-7-02 11-8-02 11-11-02 11-12-02 11-13-02 11-14-02 11-15-02 11-18-02 11-20-02 11-21-02 11-22-02 11-25-02 11-26-02 11-27-02 12-2-02 12-13-02 12-16-02 12-17-02 12-23-02 12-27-02 12-30-02 12-31-02 1-6-03 1-8-03 1-10-03 1-13-03 1-17-03 1-20-03 1-22-03 1-24-03 1-29-03 1-31-03 2-3-03 2-5-03 2-6-03 2-7-03 2-10-03 2-12-03 2-14-03 2-17-03 2-19-03 2-20-03 2-21-03 2-24-03 2-26-03 2-28-03	99213MP	\$48.00	\$48.00		\$48.00 X 75 dates = \$3600.00

3-3-03 3-5-03 3-7-03 3-10-03 3-12-03 3-14-03 3-19-03 3-21-03 3-24-03 3-26-03 3-28-03 3-31-03 5-2-03 5-5-03 5-9-03 5-12-03 6-27-03					
10-22-02 10-24-02 10-29-02 10-31-02 11-5-02 11-7-02 11-12-02 11-14-02 11-20-02 11-21-02 11-22-02 11-25-02 11-26-02 11-27-02 12-13-02 12-16-02 12-17-02 12-23-02 12-27-02 12-30-02 12-31-02 1-6-03 1-8-03 1-10-03 1-13-03 1-17-03 1-20-03 1-22-03 1-24-03 1-29-03 1-31-03 2-3-03 2-5-03 2-6-03 2-7-03 2-10-03 2-12-03 2-14-03 2-17-03 2-19-03 2-20-03 2-21-03 2-24-03 2-26-03 2-28-03 3-3-03 3-5-03 3-7-03	97250	\$61.00	\$43.00		\$43.00 X 57 dates = \$2451.00

3-10-03 3-12-03 3-14-03 3-19-03 3-21-03 3-24-03 3-26-03 3-28-03 3-31-03					
10-22-02 10-24-02 10-29-02 10-31-02 11-5-02 11-7-02 11-12-02 11-14-02 11-20-02 11-21-02 11-22-02 11-25-02 11-26-02 11-27-02 12-13-02 12-17-02 12-23-02 12-31-02 1-24-03 1-29-03 1-31-03 2-3-03 2-5-03 2-6-03 2-7-03 2-10-03 2-12-03 2-14-03 2-17-03 2-19-03 2-20-03 2-21-03 2-24-03 2-26-03	97014	\$21.00	\$15.00		\$15.00 X 34 dates = \$510.00
10-22-02 10-24-02 10-29-02 10-31-02 11-5-02 11-7-02 11-12-02 11-14-02 11-20-02 11-21-02 11-22-02 11-25-02 11-26-02 11-27-02 12-31-02 1-24-03 1-29-03 1-31-03 2-10-03 2-20-03	97010	\$16.00	\$11.00		\$11.00 X 19 dates = \$209.00
10-22-02 10-24-02 10-29-02	97035	\$31.00	\$22.00 / 15 min		\$22.00 X 45 dates = \$990.00

10-31-02 11-5-02 11-7-02 11-12-02 11-14-02 11-20-02 11-21-02 11-22-02 11-25-02 11-26-02 11-27-02. 12-13-02 12-16-02 12-17-02 12-23-02 12-27-02 12-30-02 12-31-02 1-6-03 1-8-03 1-10-03 1-13-03 1-17-03 1-20-03 1-22-03 1-24-03 1-29-03 1-31-03 2-3-03 2-5-03 2-6-03 2-7-03 2-10-03 2-12-03 2-14-03 2-17-03 2-19-03 2-20-03 2-21-03 2-24-03 2-26-03 2-28-03					
10-23-02 10-25-02 10-28-02 10-30-02 11-1-02 11-4-02 11-6-02 11-8-02 11-11-02 11-13-02 11-15-02 11-18-02	97250	\$61.00	\$43.00	\$43.00 X 12 dates = \$516.00	
10-23-02 10-25-02 10-28-02 10-30-02 11-1-02 11-4-02 11-6-02 11-8-02 11-11-02 11-13-02	97014	\$21.00	\$15.00	\$15.00 X 19 dates = \$285.00	

11-15-02 11-18-02 1-6-03 1-8-03 1-10-03 1-13-03 1-17-03 1-20-03 1-22-03					
10-23-02 10-25-02 10-28-02 10-30-02 11-1-02 11-4-02 11-6-02 11-8-02 11-11-02 11-13-02 11-15-02 11-18-02 1-6-03 1-8-03 1-10-03 1-13-03 1-17-03 1-20-03 1-22-03	97010	\$16.00	\$11.00	\$11.00 X 19 dates = \$209.00	
10-23-02 10-25-02 10-28-02 10-30-02 11-4-02 11-6-02 11-8-02 11-11-02 11-13-02 11-15-02 11-18-02	97035	\$31.00	\$22.00 / 15 min	\$22.00 X 11 dates = \$242.00	
12-2-02 12-13-02 12-16-02 12-17-02 12-23-02 12-27-02 12-30-02	97110 (4)	\$196.00	\$35.00 / 15 min	\$140.00 X 7 dates = \$980.00	
12-2-02 12-16-02 12-27-02 12-30-02	97113 (4)	\$292.00	\$52.00 / 15 min	\$208.00 X 4 dates = \$832.00	
2-3-03 2-5-03 2-12-03 2-14-03 2-17-03 2-19-03 2-21-03 2-24-03 2-26-03 2-28-03 3-3-03	97110 (2)	\$98.00	\$35.00 / 15 min		\$70.00 X 11 dates = \$770.00
2-6-03 2-7-03	97012	\$31.00	\$20.00		\$20.00 X 2 dates = \$40.00
3-5-03 3-7-03	97110 (5)	\$245.00	\$35.00 / 15 min		\$175.00 X 12 dates = \$2100.00

3-10-03					
3-12-03					
3-14-03					
3-19-03					
3-21-03					
3-24-03					
3-26-03					
3-28-03					
3-31-03					
4-2-03					
TOTAL				\$3064.00	\$10,670.00

On this basis, the total amount recommended for reimbursement (\$3064.00) 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.

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

On December 22, 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.

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

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services identified above. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
11-1-02	97035	\$31.00	\$0.00	No EOB	\$22.00 / 15 min	CPT Code Descriptor	MAR reimbursement of \$22.00 + \$96.00 + \$86.00 + \$208.00 + \$140.00 + \$175.00 = \$727.00 is recommended.
12-3-02 4-28-03	99213MP	\$68.00	\$0.00	No EOB	\$48.00 X 2 = \$96.00		
12-3-02 12-11-02	97250	\$61.00	\$0.00	No EOB	\$43.00 X 2 = \$86.00		
12-11-02	97113(4)	\$292.00	\$0.00	No EOB	\$52.00 / 15 min X4 = \$208.00		
12-11-02	97110(4)	\$196.00	\$0.00	No EOB	\$35.00 / 15 min X 4 = \$140.00		
4-4-03	97110 (5)	\$245.00	\$0.00	No EOB	\$35.00 / 15 min X 5 = \$175.00		

This Decision is hereby issued this 23rd day of August 2004

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

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 Decision is applicable for dates of service 10-21-02 through 6-27-03 in this dispute.

This Order is hereby issued this 23rd day of August 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION - AMENDED

Date: December 23, 2003

RE: MDR Tracking #: M5-04-0552-01
IRO Certificate #: 5242

___ 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 proposed 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 Chiropractor who has a temporary ADL exemption. The Chiropractor 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

According to the documentation provided for review the claimant lifted an air compressor on or about ___ and experienced low back pain. The claimant complained of pain and symptoms into both of his legs. The claimant reportedly began chiropractic care with ___ on or about 10/10/02 after changing treating physicians. Electrodiagnostic studies were done and an MRI was also performed. The MRI did show disc herniations at L4/5 and L5/S1. The L5/S1 herniation was felt to be abutting against the right S1 nerve root. The electrodiagnostic impressions reportedly showed "irritation of the lumbar nerve roots"; however, the specificity of this should be highly questioned and it appears an EMG was not done. The overall documentation is also conflicting with respect to the electrodiagnostic work up because ___ felt the claimant had EMG evidence of nerve root irritation at a nonspecified level when it was documented by ___ on 1/18/03 that the claimant's electrodiagnostic work up was normal. At any rate, the claimant underwent 3 epidural steroid injections sometime between 11/19/02 and 1/2/03. The third epidural steroid injection occurred on 1/2/03; however, the documentation does not state or show when the first and second epidural steroid injections were performed. ___, an orthopedic surgeon, recommended epidural steroid injections on 11/19/02 due to lack of progression. An functional capacity exam of 1/14/03 revealed that the claimant was unable to finish the testing due to pain. The claimant did see ___ for an independent medical exam on 1/18/03 and was not found to be at maximum medical improvement. It should be noted that ___ report specifically stated the chiropractic treatment has not helped and that sometimes the claimant's back hurt worse after the treatments. Again, ___ report stated the electrodiagnostic studies were normal. ___ requested a lumbar discogram be done on 1/21/03 because the claimant had failed to progress via the treatment to date as well as the epidural steroid injections. The claimant has also seen ___ for pain management. The claimant also saw ___ for a designated doctor evaluation on 4/30/03 and the claimant was still felt not to be at maximum medical improvement. It should be noted the claimant was felt not to be at maximum medical improvement when he saw ___ back on 1/18/03 as well. The documentation also suggests that the claimant was to begin a chronic pain management program on 5/15/03; however, I am not sure if this occurred. It should also be noted that the services in question, which run from 10/22/02 through 6/27/03 comprise 80 chiropractic visits.

Requested Service(s)

Office visit with manipulation, myofascial release, electric stimulation therapy, hot/cold pack therapy, ultrasound therapy, aquatic therapy, therapeutic exercises, mechanical traction therapy from 10/22/02 through 6/27/03.

Decision

I agree with the insurance carrier and find that most of the services in dispute were not reasonable and medically necessary. However, I disagree with the carrier and find that the chiropractic care rendered prior to 11/19/02 was medically necessary at only 3 times

per week, not 5 times per week as documented. I further disagree with the carrier and find that the active chiropractic care to include the active codes as well as the manipulation and office visit codes which were rendered for up to 6 visits over no longer than a 2 week period immediately following each epidural steroid injection were medically necessary. I will discuss this more thoroughly in the rationale portion below. I agree with the insurance carrier and find that the chiropractic office visits billed at the 99213 level were not supported as medically necessary as the chiropractic documentation submitted for review indicates the 99212 code would have been more characteristic of the documentation than was the 99213 code. To repeatedly bill for a 99213 code for 80 visits through June 2003 for a well defined focused condition without apparent change in the claimant's condition is not medically necessary and the entirety of the chiropractic office visit codes which are in dispute should have billed at the 99212 level instead of the 99213 level. Again, the chiropractic documentation for each visit was extremely minimal and did not meet the criteria needed for billing of a 99213 code. I have created a table to make what is authorized and not authorized more understandable:

Date	Authorized	Not Authorized
10/21/02	All but 99213MP should be 99212MP	
10/22/02	None	All
10/23/02	All but 99213MP should be 99212MP	
10/24/02	None	All
10/25/02	All but 99213MP should be 99212MP	
10/28/02	All but 99213MP should be 99212MP	
10/29/02	None	All
10/30/02	All but 99213MP should be 99212MP	
10/31/02	None	All
11/1/02	All but 99213MP should be 99212MP	
11/4/02	All but 99213MP should be 99212MP	
11/5/02	None	All
11/6/02	All but 99213MP should be 99212MP	
11/7/02	None	All
11/8/02	All but 99213MP should be 99212MP	
11/11/02	All but 99213MP should be 99212MP	
11/12/02	None	All
11/13/02	All but 99213MP should be 99212MP	
11/14/02	None	All
11/15/02	All but 99213MP should be 99212MP	
11/18/02	All but 99213MP should be 99212MP	
12/2/02	99212 (not 99213)	All others
12/17/02	99212 (not 99213)	All others
1/6/03	99213MP should be 99212MP, 97010, 97014	97035, 97250
1/8/03	99213MP should be 99212MP, 97014, 97010,	97035, 97250
1/10/03	97014, 97010	97035, 97250
1/13/03	99213MP should be 99212MP, 97014, 97010	97035, 97250
1/17/03	99213MP should be 99212MP, 97014, 97010	97035, 97250
2/3/03	99212 (not 99213)	All others
2/17/03	99212 (not 99213)	All others
3/3/03	99212 (not 99213)	All others
3/19/03	99212 (not 99213)	All others
4/4/03	99212 (not 99213)	All others
4/28/03	99212 (not 99213)	
5/12/03	99212 (not 99213)	
6/27/03	99212 (not 99213)	

In addition to the above table, the claimant had epidural steroid injections on two other dates, which are not documented. Treatment up to two weeks post-injection, with a maximum of 3X/week, would be reasonable and necessary after each injection. Authorized and unauthorized CPT codes should follow the guide of treatment from 1/6/03 to 1/17/03.

All other services rendered are not considered to be medically necessary.

Rationale/Basis for Decision

It was documented that the claimant underwent at least 21 visits of chiropractic treatment of the passive care variety from 10/22/02 through 11/18/02 when the claimant saw ___ on 11/19/02. It was also documented that the claimant initiated chiropractic care on 10/10/02, therefore, the 21 visits rendered from 10/22/02 through 11/18/02 may have actually been 31 visits or more because the claimant obviously began chiropractic care prior to the first disputed date of service which was 10/22/02. This would be considered more than an adequate trial of chiropractic care and I find that the daily treatment which was rendered through the 3rd week in November was excessive. It is not reasonable and customary to see a claimant on a daily basis except for in the initial acute stage of the injury during the first week of treatment and during a work hardening program, work conditioning program or chronic pain management program. The amount of treatment with respect to its frequency was excessive and did not correlate with any of the evidence based guidelines recommendations. It was also documented in ___ note of 11/19/02 that the claimant was not doing well at all and this necessitated further action in the form of epidural steroid injections, the last of which occurred on 1/2/03. It is my opinion that it is reasonable and customary for the claimant to undergo active rehabilitation at 3-6 visits over a 2 week period immediately following the administration of an epidural steroid injection. Therefore, considering the fact that the last injection was 1/2/03, the active care rendered through 1/17/03 would be considered medically necessary. Unfortunately I do not know the dates of the first and second epidural steroid injection, therefore, it is difficult to speculate on what was medically necessary during the first and second epidural steroid injections. However, suffice it to say that 3-6 visits of active care only combined with office visits and manipulation billed at 99212 would have been fine. Passive treatment of any kind beyond at least 11/18/02 would not have been considered medically necessary as, by this date, the claimant had undergone anywhere from 20-30 chiropractic visits and passive care was simply not warranted beyond the first 2-4 weeks of the injury and especially in the presence of non-progression. It was documented during a follow up of 1/21/03 with ___ that the claimant had failed to progress via the conservative treatment and epidural steroid injections provided to date. In fact, ___ recommended that the discogram be done because it was his opinion that surgery was needed. It should also be noted that ___ saw the claimant on 1/18/03 and it was stated the claimant was not doing well and the chiropractic care actually worsened his condition at times. Therefore, taking this into consideration as well as the functional capacity exam which was done which showed the claimant could barely function, I do feel the claimant had exhausted all reasonable attempts at conservative chiropractic intervention. The only reasonable chiropractic intervention would have been twice per month chiropractic office visits billed at the 99212 level

through the end of the disputed services of 6/27/03. These office visits at twice per month would have been medically necessary in my opinion for monitoring purposes and simply because ___ was the treating physician of record. It should also be noted that ____, who provided the claimant with epidural steroid injections, reportedly stated that 3-6 weeks of physical therapy is needed for each injection the claimant had. This is not reasonable and customary as it is well known in the medical community that only about 3-6 visits of physical therapy of the active variety is all that is needed for each epidural steroid injection which occurs. If the claimant is going to gain any benefit from epidural steroid injections, it will be known in the first 2 weeks at which time the claimant should be transitioned into a work hardening program. If the claimant cannot tolerate at work hardening program or work conditioning program, then further surgical consideration needs to be afforded. At any rate, just because a claimant is not progressing does not mean that further chiropractic treatment is supported as medically necessary. The claimant has undergone 80 chiropractic visits from 10/21/02 through 6/27/03 and this is far in excess of the recommendations of the highly evidence based Official Disability Guidelines. In summary, I do feel that the chiropractic treatment which was rendered through 11/18/02 at 3 times per week, not 5 times per week, was medically necessary as billed. However, I do feel that the 99213 code was not substantiated by the documentation and the 99212 code was more appropriate given the documentation. It is also my opinion in summary that the active chiropractic treatment to include manipulation and a 99212 code would have been medically necessary at 3-6 visits to immediately follow each epidural steroid injection. However, as of 1/21/03 it was obvious the claimant was not progressing and ___ recommended a discogram for surgical purposes. It was clear from this point onward that further supervised chiropractic treatment of any kind was not medically necessary except for twice per month office visits billed at 99212 for monitoring purposes only.