

MDR Tracking Number: M5-04-0816-01

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 11-17-03.

The IRO reviewed office visits, electric stimulation, hot/cold packs, and therapeutic activities from 12-17-02 through 7-17-03.

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.

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 2-9-04, 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 requestor failed to submit relevant information to support components of the fee dispute for dates of service 12-21-02 and 7-17-03 in accordance with Rule 133.307(g)(3)(A-F). No reimbursement recommended.

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

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
12/27/02	97010	\$15.00	\$0.00	No EOB	\$11.00	Rule 133.307(g)(3) (A-F)	Relevant information does not support delivery of service. No reimbursement recommended.
1/10/03	99080	\$15.00		F	\$15.00		
2/21/03	99213	\$50.00		No EOB	\$48.00		Relevant information supports delivery of service. Recommend reimbursement of \$48.00.
TOTAL		\$80.00	\$0.00				The requestor is entitled to reimbursement of \$48.00.

## 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 date of service 2-21-03 in this dispute.

This Order is hereby issued this 21<sup>st</sup> day of April 2004.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

February 3, 2004

IRO Certificate # 5259  
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An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by \_\_\_ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

\_\_\_ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to \_\_\_.

### CLINICAL HISTORY

Available information suggests that this patient reports injury occurring \_\_\_ as a result of a strain to his lower back while at work. He appears to present initially to a \_\_\_ and is treated conservatively for lumbosacral sprain. An MRI performed 9/12/02 suggesting some level of disc herniation at L5/S1 levels. The patient then begins seeing a chiropractor, \_\_\_, on or about 9/17/02 and begins treatment consisting of therapeutic exercise, joint mobilization, electric stimulation and myofascial release through 11/6/02. The patient requests a change to see another chiropractor indicating that previous chiropractic care was not helping. He appears to begin seeing another chiropractor, \_\_\_ on or about 12/2/02. Treatment with \_\_\_ appears to be essentially the same as previous chiropractic care including chiropractic adjustments, joint mobilization, electric

stimulation and hot/cold packs. EMG/NCV studies are performed on 12/21/02 suggesting some bilateral radiculopathy at L4, L5 and S1 levels.

The patient is then referred to an anesthesiologist, \_\_\_\_, who appears to perform epidural steroid injections on 2/18/03. Finally, there is a medical evaluation provided by a \_\_\_\_ on 4/10/03 suggesting that the patient has not improved with chiropractic treatment and should be seen for neurosurgical evaluation in order to appropriately address ongoing discopathy and radiculopathy.

#### REQUESTED SERVICE (S)

Determine medical necessity for items in dispute (office visits, electric stimulation, hot/cold packs and therapeutic activities) from 12/17/02 through 7/17/03.

#### DECISION

Medical necessity for these ongoing chiropractic treatments is not supported by generally accepted treatment guidelines and clinical literature.

#### RATIONALE/BASIS FOR DECISION

Services performed by subsequent chiropractor (12/17/02 – 7/17/03) appear to be essentially a duplication of services already performed by a previous chiropractor. With discogenic radiculopathy objectively documented, appropriate surgical evaluation would have been indicated before continuing with this protocol.

1. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. *J Manipulative Physiol Ther* 2002; 25(1):10-20.
2. Bigos S., et al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
3. Hoving JL, Koes BW, de Vet HCW, van der Windt DAWM, Assendelft WJJ, van Mameren H, et al. Manual therapy, physical therapy or continued care by a general practitioner for patients with back pain. A randomized, controlled trial. *Ann Int Med* 2002; 136:713-722.
4. Morton JE. Manipulation in the treatment of low back pain. *J Man Manip Ther* 1999; 7(4): 182-189.
5. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review.

This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute a per se recommendation for specific claims or administrative functions to be made or enforced.