

MDR Tracking Number: M5-04-0857-01

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 11-20-03.

Dates of service prior to 11-20-02 were submitted untimely per above referenced rule and will not be considered further in this decision.

The IRO reviewed office visit, electric stimulation – unattended, unlisted therapeutic procedure, mechanical traction, chiropractic manipulative treatment, required reports, hot/cold pack therapy rendered from 11-20-02 through 9-23-03 that were denied based upon “V”.

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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

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

On February 18, 2004, 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	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
2-3-03	99213	\$48.00	\$0.00	No EOB	\$48.00	CPT Code Descriptor	The MAR of \$48.00 is recommended.
2-3-03	97014	\$15.00	\$0.00	No EOB	\$15.00		The MAR of \$15.00 is recommended.
5-27-03	99213	\$48.00	\$0.00	R	\$48.00	Section 408.027(d)	CCHI found that claimant sustained a compensable injury. Services will be reviewed in accordance with MAR of MFG. The MAR of \$48.00 is recommended
TOTAL							The requestor is entitled to reimbursement of \$111.00 .

IV. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for CPT code(s) 99213 and 97014 in the amount of **\$111.00**. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby **ORDERS** the Respondent to remit **\$111.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 7th day of September 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

February 11, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: MDR Tracking #: M5-04-0857-01
 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 an injury on ___ when he fell off a battery and hit the ground on his left side. X-rays revealed a hairline fracture of the lateral left fifth rib. He initially saw a physician in Mexico. He eventually saw a chiropractor for evaluation and treatment on 08/15/02.

Requested Service(s)

Office visits, electrical stimulation-unattended, unlisted therapeutic procedure, mechanical traction, chiropractic manipulative treatment, office visit for evaluation, required reports, manipulation-each additional area, hot/cold pack therapy, and office visit-may not require a physician from 11/06/02 through 09/23/03

Decision

It is determined that the office visits, electrical stimulation-unattended, unlisted therapeutic procedure, mechanical traction, chiropractic manipulative treatment, office visit for evaluation, required reports, manipulation-each additional area, hot/cold pack therapy, and office visit-may not require a physician from 11/06/02 through 09/23/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient complained of severe constant left hip, left shoulder, wrist, and right knee pain. The neurological examination was unremarkable and lumbar orthopedic tests were locally positive. He was returned to work on 08/15/02 without restrictions at full duty.

A review of the patient's progress notes revealed no appreciable change in his condition in spite of the 13 months (81 visits) of care rendered. The patient's self-reported pain scores did not change appreciably over the first four months of treatment and the examinations revealed no evidence of substantive benefits derived from the chiropractic treatment regimen employed for the treatment of the patient. In light of the lack of response to treatments rendered by the chiropractor, treatments after 11/04/02 were not medically necessary.

Current treatment guidelines indicate that adequate trial of care is identified 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, Gaitherburg, Maryland, 1993*). The patient had a protracted course of care in excess of the parameters delineated by the above-mentioned document and has not demonstrated a favorable response to treatment.

Chiropractic literature indicates that little is to be gained from prolonged courses of chiropractic care if there has not been adequate response in the first month of care. Bronfort (*Bronfort, G., "Chiropractic treatment of low back pain: A prospective survey", JMPT, 9:99-113, 1986*), found that there was little improvement occurring in patients who responded poorly to the first month of care. The maximum benefits of manipulation are realized in the first month of care in the majority of patients, with diminishing returns after the first month of treatment. A review of the progress notes from the first month of care revealed no change in the patient's condition. Therefore, it is determined that the office visits, electrical stimulation-unattended, unlisted therapeutic procedure, mechanical traction, chiropractic manipulative treatment, office visit for evaluation, required reports, manipulation-each additional area, hot/cold pack therapy, and office visit-may not require a physician from 11/06/02 through 09/23/03 were not medically necessary.

Sincerely,