

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, 133.307 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 January 21, 2004.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that CPT Code 97035, ultrasound, CPT Code G0283, electrical stimulation, and chiropractic manipulation, CPT Code 98941 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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 April 5, 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 19 days of the requestor's receipt of the Notice.

- In accordance with Rule 180-22(c)(1), the requestor billed CPT Codes 99213-MP, G0283, and 97035 for date of service February 5, 2003. The carrier denied these codes as "L – This treatment does not appear to be order by the treating doctor". On January 14, 2002 the treating doctor referred the injured worker for 6 weeks of chiropractic care. The requestor has not submitted an updated referral from the treating doctor for continued chiropractic care and the injured worker has not submitted a TWCC-53 requesting a change of treating doctors. Therefore, reimbursement is not recommended.
- In accordance with Rule 134.202(b), the requestor billed CPT Code G0283 for date of service 10/15/03. The carrier denied the CPT code as "AG – Medicare Fee Schedule reimbursement is not valid for this service". The Medicare Fee Schedule lists this code as a valid code. The requestor has submitted relevant information to support delivery of service. The requestor billed \$11.00 for this service. Medicare Fee Schedule reimbursement times 125% is \$14.91 (\$11.93 x 125%); however, reimbursement is recommended in the amount of \$11.00.

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 date of service 10/15/03 and 02/05/03 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 Decision and Order is hereby issued this 30th day of September 2004.

Marguerite Foster  
Medical Dispute Resolution Officer  
Medical Review Division

MF/mf  
Enclosure: IRO Decision



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## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** March 26, 2004

**MDR Tracking #:** M5-04-1424-01  
**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 Chiropractic reviewer who has an ADL certification. The reviewer 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, it appears \_\_\_\_\_ suffered injury to multiple body areas when a TV either fell on her or she caught the TV which fell from a cabinet and this caused her to be knocked into a chair. The claimant appeared to have complaints of thumb pain bilaterally, hand pain bilaterally, ankle pain, low back pain, pelvis and neck pain, and shoulder region pain. The claimant has undergone surgery on her left foot and right foot and has also undergone surgery on her right knee in the year 2000. The right foot surgery took place in 1999 and the left foot surgery took place in 2001. The claimant has undergone bone scan of the left foot as well as MRI evaluations of the cervical and lumbar spine and all of these notes were reviewed. The claimant also saw \_\_\_\_\_ for her foot problem. X-rays and MRI evaluations revealed degenerative changes. There was no evidence of neurological stenosis based upon the report of the MRI films. The claimant has been undergoing chiropractic care with \_\_\_\_\_. The documentation revealed that the claimant had been undergoing chiropractic care prior to the 1998 injury, mainly in connection with her cervical spine dysfunction and migraine headache symptoms.

### **Requested Service(s)**

Please review and address the medical necessity of the outpatient services to include ultrasound, electrical stimulation, chiropractic manual treatment for the dates of 2/5/03 through 10/15/03. It should be noted that the dates of service only encompass four (4) dates of service to include 2/5/03, 9/4/03, 9/30/03 and 10/15/03. The explanation of benefits documentation reveals that the 98941 or manipulation code was paid on 9/30/03 and 9/4/03. It was not paid on 10/15/03 or 2/5/03.

### **Decision**

I agree with the insurance carrier and find that the services in dispute were not medically necessary.

### **Rationale/Basis for Decision**

The initial documentation on the same day of the injury from the chiropractor mentions very little, if anything, about low back problems. In fact, the \_\_\_ date of service note from the chiropractor which occurred on the same day of the injury, mentioned that the claimant only had neck pain and upper and mid-back pain along with muscle tenderness and fixations. The initial documentation from shortly after the injury through at least May of 2000 mentions little, if anything, about low back problems or radicular problems or even ankle problems for that matter. In fact, the chiropractic documentation on the same day of the injury of \_\_\_ mentions only the presence of upper thoracic mid-back pain and neck pain along with fixations and muscle tenderness. X-rays provided for review revealed pre-existing degenerative changes and it was \_\_\_ opinion that the claimant had an underlying arthritic problem involving multiple joints. In fact, I will read from his 8/20/02 note which states, “\_\_\_, \_\_\_ case manager, came in and we went over in detail the nature and degree of the problems, multiple as they are in context, of the admittedly bizarre history of sorts that accompanies this patient’s injury in the face of her underlying arthritic problem in multiple joints, complicated of course by the work related injury to multiple sites”. A 10/10/00 note from the chiropractor stated that the claimant had a prior history of cervical neck dysfunction that produced migraine type headaches and that he was mainly seeing the claimant for her low back, left lower extremity, thumb and upper thoracic pain as it pertained to the \_\_\_ injury. Again, there was no initial mention by the chiropractor shortly after the injury of low back pain or problems in either the TWCC-64 or the TWCC-61 reports through May of 2000. The claimant only had complaints and findings suggestive of neck and upper mid-back problems through May of 2000 and multiple TWCC-64 and TWCC-61 reports show diagnoses were solely related to the ankle, neck and mid-back. I understand that a television fell on this claimant, or she caught a TV and this has caused her to land in a chair. However, this would not cause ongoing long term sequelae, especially given the pre-existing degenerative changes, the alleged underlying arthritic condition and the non-compressive cervical and lumbar findings. The claimant has also reportedly undergone two foot surgeries and a knee surgery and to attribute this to catching a TV and landing in a chair quite frankly does not make clinical sense. Other areas of concern are the \_\_\_ chiropractic daily note on the same date of injury that only mentions fixations and tightness in the upper back and neck. The claimant appears to be having ongoing knee, foot, pelvis, low back, neck, and headache problems, when the initial documentation revealed that the claimant was mainly having neck and upper back problems only. A 12/13/98 note stated that, “The claimant is still having problems with her foot

pain and right sided neck pain.” Again, there is no mention at this time of a diagnosis, complaint or finding involving any other body areas. A TWCC-61 report shortly after this reveals there to be only diagnoses of cervical and thoracic sprain/strain and ankle sprain/strain. It was stated by the chiropractor on 4/27/99 that, “The patient has done well over the last four weeks and required only limited care during this time.” I fail to see how the listed disputed services of passive care would have anything to do with a \_\_\_ injury, especially given this statement by the chiropractor made back on 4/27/99. A 4/27/99 TWCC -64 report revealed the diagnoses had changed to cervical intervertebral disc syndrome without myelopathy and cervical radiculopathy. Again, there is no mention of low back problems, ankle problems. This could be because the chiropractor was mainly taking care of the spinal related problems and the ankle and knee problems were not mentioned because of this. At any rate, this does not explain the apparent lapse of low back problems for nearly two years post injury. Please also consider the pre-existing problem involving the neck and the migraine headaches for which the claimant also appears to still be receiving palliative care. Please also note that the lumbar MRI of 10/2/00 revealed “normal study”. However, this study was referred over to a chiropractic radiologist who felt that the claimant had degenerative changes at the L4-L5 area and some disc desiccation, which of course would not be injury related. There was no evidence of neurological stenosis whatsoever. A 5/30/02 note from the foot surgeon, who in this case was \_\_\_\_, stated that the claimant’s neck, shoulder and headache problems are “associated with what I think is a true systemic form of arthritis as well as the injury that she suffered on the job”. At any rate, it is quite clear that the overlying sprain/strain and contusion type injury the claimant sustained as a result of the \_\_\_ work related injury would have resolved, leaving her with ongoing complaints due to normal life occurrences and events and pre-existing conditions. This appears quite clear from the documentation. This is not to say that she did not aggravate a pre-existing condition, however, the aggravation portion of that injury is resolved. The services rendered were passive and, within a large degree of medical probability, directed toward a normal life occurrence and pre-existing condition that was aggravated. It is highly doubtful that the services rendered some 5 years post injury would be related to the effects of the specific \_\_\_ work injury.