

**MDR Tracking Number: M5-04-1484-01**

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on January 26, 2004.

The 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 the neuromuscular re-education, manual traction, massage therapy, myofascial release, office visits, therapeutic exercises, therapeutic procedure, hot/cold packs, electrical stimulation unattended, and unlisted therapeutic procedure rendered from 7/8/03 through 11/3/03 were not found to be 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 March 30, 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:

DOS	CPT CODE	Billed	MAR	Paid	EOB Denial Code	Rationale
7/17/03	97112 x 2 units	\$70.00	\$35/unit x 2 = \$70.00	\$0.00	No EOB	Both the requestor and the respondent failed to submit copies of EOBs, however, proof of re-consideration was submitted with the dispute packet, therefore the disputed charge will be reviewed according to the 1996 Medical Fee Guidelines. The requestor did not submit relevant information to support delivery of service. Reimbursement is therefore not recommended and the division declines to issue an Order in this dispute.
7/17/03	97112 x 2 units	\$70.00	\$35/unit x 2 = \$70.00	\$0.00	No EOB	
8/12/03	97250	\$43.00	\$43.00	\$0.00	No EOB	
8/14/03	97250	\$43.00	\$43.00	\$0.00	No EOB	
TOTAL		\$226.00	\$226.00	\$0.00		

This Decision is hereby issued this 8<sup>th</sup> day of October 2004.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division  
MQO/mqo

**NOTICE OF INDEPENDENT REVIEW DETERMINATION**

**REVISED 3/29/04**

MDR Tracking Number: M5-04-1484-01  
IRO Certificate Number: 5259

March 19, 2004

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 Texas Medical Foundation, 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 \_\_\_.

Sincerely,

CLINICAL HISTORY

Patient was treated by multiple doctors and received extensive physical medicine treatments after falling off a ladder at work on \_\_\_.

REQUESTED SERVICE(S)

Neuromuscular re-education, manual traction, massage therapy, myofascial release, office visits, therapeutic exercises, therapeutic activities, hot/cold pack therapy, electrical stimulation unattended, unlisted therapy procedures and manual therapy techniques from 07/08/03 through 11/05/03.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

While the records appear to indicate that the patient's subjective pain ratings decreased with treatment, there is no objective documentation of that. In fact, there is no objective documentation of any functional improvement whatsoever.

Although cervical ranges of motion were recorded on 07/08/03, lumbar ranges of motion were not reported. When next examined on 10/20/03, lumbar ranges of motion were recorded, but cervical ranges of motion were not reported. As a result, there is no documentation that any functional improvement occurred in either area.

In fact, lumbar orthopedic tests reveal the patient was actually worse after the treatment. The examination performed 07/08/03 listed all orthopedic tests (including Kemp's test) as being negative. However, the re-examination on 10/20//03 indicated that Kemp's test was positive bilaterally and that the patient exhibited a positive Bechterew's Sitting test. Had the physician's treatment been remotely beneficial, medically necessary or had it relieved the patient's symptoms, those tests would certainly not be positive, after being negative originally.