

MDR Tracking Number: M5-04-1532-01

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, 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 01-29-04.

The IRO reviewed office visits, myofascial release, ultrasound therapy, electrical stimulation-unattended, hot/cold pack therapy and electrodes rendered from 02-28-03 through 03-12-03 that were denied based "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 04-20-04, 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.

CPT code 99213 on dates of service 02-28-03 and 03-12-03 per the explanation of benefits from the respondent were paid at the MAR of \$48.00 per the 1996 Medical Fee Guideline EVALUATION/MEDICINE GR(VI)(B). No additional reimbursement recommended. The requestor nor the respondent submitted an explanation of benefits for denial of CPT code 97010 date of service 03-12-03. Reimbursement per the 1996 Medical Fee Guideline MEDICINE GR (I)(9)(a)(ii) in the amount of \$11.00 is recommended for CPT code 97010 date of service 03-12-03.

### **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 date of service 03-12-03 in this dispute.

This Findings and Decision and Order are hereby issued this 23<sup>rd</sup> day of September 2004.

Debra L. Hewitt  
Medical Dispute Resolution  
Medical Review Division  
DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

April 14, 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 #:    M5-04-1532-01  
              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 has worked as a directory assistance operator. The date of injury was \_\_\_; however, the mechanism is unknown. The patient complains of numbness and tingling in both fingers and hands. The patient has used a muscle stimulator, ultrasound, soft tissue mobilization, trigger point injections and takes Motrin for pain control.

Requested Service(s)

Office visits, myofascial release, ultrasound, electrical stimulation-unattended, hot/cold pack therapy, and electrodes from 02/28/03 through 03/12/03.

## Decision

It is determined that the office visits, myofascial release, ultrasound, electrical stimulation-unattended, hot/cold pack therapy, and electrodes from 02/28/03 through 03/12/03 were not medically necessary.

## Rationale/Basis for Decision

The patient was treated with manipulation and passive modalities and the dates of service in question were almost two years post-injury. While manipulation is medically necessary form of treatment in the management of nonspecific spinal disorders, the maximum therapeutic benefit for spinal manipulation is noted in the first 2 to 3 weeks of care. The maximum therapeutic benefit for chiropractic treatment regimens that do not incorporate a shift away from passive care to active and rehabilitative care will be realized in a few weeks, beyond which the medical necessity of continued manipulation is questionable. Therefore, the office visits and passive modality treatments rendered from 02/28/03 through 03/12/03 were not medically necessary for the treatment of the patient's condition.

Sincerely,