

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER: 453-05-4267.M5

MDR Tracking Number: M5-04-1670-01

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 02-09-04.

The IRO reviewed conference by physician, chiropractic manipulative treatment, therapeutic exercises, prolonged evaluation, electrical stimulation, unlisted therapy, neuromuscular re-education, massage therapy, office visits and group therapy, myofascial release, physician perfusion testing, manipulation each additional area, range of motion (ROM) measure, therapeutic procedure, manual therapeutic technology, therapeutic activity, hot/cold pack therapy, joint mobilization from 06-04-03 through 09-03-03 and physical therapy re-evaluation for dates of service 06-04-03 through 09-04-03 that were denied based upon "V".

The IRO determined that the therapeutic exercises, neuromuscular re-education and electrical stimulation from 06-04-03 through 07-16-03, muscle testing study done on 07-14-03, ROM measure done on 07-15-03, manual therapy from 08-11-03 through 08-18-03, unlisted modality from 08-11-03 through 08-20-03, therapeutic exercises and therapeutic activities from 08-11-03 through 09-03-03, the conference by physician and office visits and group therapy from 06-04-03 through 09-03-03 **were** medically necessary. The IRO determined that the use of spinal manipulation, joint mobilization, spinal manipulation additional area and unlisted modality from 07-01-03 through 07-16-03, myofascial release and massage, spinal manipulation from 08-18-03 through 09-03-03, extremity manipulation from 08-11-03 through 08-14-03, electrical stimulation and hot/cold packs from 08-11-03 through 09-03-03, unlisted modality from 08-27-03 through 09-03-03 and physical therapy re-evaluation for dates of service 06-04-03 through 09-04-03 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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 06-08-04, 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 99080-73 date of service 02-27-03 denied with denial code "F/Z651" (this charge has been reimbursed according to the appropriate fee schedule or usual and customary value). The carrier has made no payment. Per Rule 134.202(e)(1) reimbursement is recommended in the amount of \$15.00.

CPT code 99080-73 dates of service 07-22-03 and 08-19-03 denied with denial code "V" (unnecessary medical with peer review). Per Rule 129.5 the TWCC-73 is a required report and not subject to an IRO review. Reimbursement is recommended in the amount of \$30.00 (\$15.00 X 2 DOS).

CPT code 99080-73 date of service 09-10-03 is listed on the table of disputed services. Per the EOB provided by the respondent payment was made in the amount of \$15.00 on 10-27-03 via check number 06860840, therefore this service is no longer in dispute.

CPT codes 99358-52 dates of service 08-04-03 and 09-08-03 denied with denial code "G/B377" (bundled procedure, no separate payment allowed). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service code 99358-52 was global to. Reimbursement is recommended per Rule 134.202(b)(1) in the amount of \$60.00 (\$30.00 X 2 DOS).

**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) and in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), 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 dates of service 06-04-03 through 09-08-03 in this dispute.

This Findings and Decision and Order are hereby issued this 31<sup>st</sup> day of January 2005.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

**NOTICE OF INDEPENDENT REVIEW DECISION**

May 14, 2004

**Amended Letter 01/26/05**

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

RE: Injured Worker: M5-04-1670-01  
MDR Tracking #: IRO4326  
IRO Certificate #:

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 Medicine. TMF'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 TMF 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 48 year-old female had an industrial-related accident on \_\_\_\_\_. On 06/12/02, she had a right carpal tunnel release, and trigger release, right 3<sup>rd</sup> digit. On 04/16/03, the patient underwent a left carpal tunnel release as

well as release of ulnar nerve at the wrist on the left. Medical record documentation states on 04/30/03, the patient was not at maximum medical improvement (MMI). On 04/16/03, she had carpal tunnel release on the left wrist. On 06/04/03, the chiropractic office notes states the patient cannot drive with the left hand. On 07/17/03, she had a trigger release of the right thumb. On 09/09/03, the patient returned to work with light duty.

#### Requested Service(s)

The conference by physician, chiropractic manipulative treatment, therapeutic exercises, prolonged evaluation, electrical stimulation, unlisted therapy, neuromuscular reeducation, massage therapy, office visits and group therapy, myofascial release, physician perfusion testing, manipulation each additional area, range of motion (ROM) measure, therapeutic procedure, manual therapeutic technology, therapeutic activity, hot-cold pack therapy, joint mobilization, chiropractic manipulative treatment, and electrical stimulation from 06/04/03 through 09/03/03 and physical therapy re-evaluation for dates of service 06/04/03 through 09/04/03.

#### Decision

It was determined that the therapeutic exercises, neuromuscular reeducation and electrical stimulation from 06/04/03 through 07/16/03, muscle testing study done on 07/14/03, ROM measure done on 07/15/03, manual therapy from 08/11/03 through 08/18/03, unlisted modality form 08/11/03 through 08/20/03, therapeutic exercises and therapeutic activities from 08/11/03 through 09/03/03, the conference by physician and office visits and group therapy from 06/04/03 through 09/03/03 were medically necessary to treat this patient.

It was determined that the use of spinal manipulation, joint mobilization, spinal manipulation additional area and unlisted modality from 07/01/03 through 07/16/03, myofascial release and massage, spinal manipulation from 08/18/03 through 09/03/03, extremity manipulation from 08/11/03 through 08/14/03, electrical stimulation and hot/cold packs from 08/11/03 through 09/03/03, unlisted modality from 08/27/03 through 09/03/03 and physical therapy re-evaluation for dates of service 06/04/03 through 09/04/03 were not medically necessary to treat this patient.

#### Rationale/Basis for Decision

The therapeutic exercises, neuromuscular reeducation, and electrical stimulation from 06/04/03 through 07/16/03 were medically necessary to treat the patient's condition. The muscle testing study performed on 07/14/03 and the ROM study performed on 07/15/03 were medically necessary.

The use of spinal manipulation, joint mobilization, spinal manipulation additional area and unlisted modality from 07/01/03 through 07/16/03 were not medically necessary to treat the patient's condition as the medical records did not document that these treatments occurred.

The use of myofascial release and massage were not medically necessary to treat the patient's condition. O'Conner et al evaluated the effectiveness of non-surgical (other than steroid injection) for carpal tunnel syndrome versus a placebo or other non-surgical, control interventions in improving clinical outcome. Randomized or quasi-randomized studies in any language of participants with the diagnosis of carpal tunnel syndrome that had not previously undergone surgical release were reviewed and all non-surgical treatments apart from local steroid injection were considered. The primary out come measure was improvement in clinical symptoms after at least three months following the end of treatment. Twenty-one trials involving 884 people were included. Trials of magnet therapy, LASER acupuncture, exercise or chiropractic care did not demonstrate symptom benefit when compared to placebo or control. The reviewers concluded that current evidence shows significant short-term benefit from oral steroids, splinting, ultrasound, yoga and carpal bone mobilization. Other non-surgical treatments do not produce significant benefit. (*O'Conner, D, et al, "Non-surgical treatment (other than steroid injections) for carpal tunnel syndrome", (Cochrane Review), in The Cochrane Library, Issue 1, 2003, Oxford*)

The patient had a trigger release surgery on 07/17/03 and the use of manual therapy from 08/11/03 to 08/18/03 is medically necessary for treatment of the patient's condition. The use of spinal manipulation was not medically necessary from 08/18/03 through 09/03/03. The patient did not have a spinal diagnosis and no evidence of a spinal problem was noted in the documentation reviewed. The use of extremity manipulation

from 08/11/03 through 08/14/03 was not medically necessary as the progress notes did not note the presence of joint fixations that would necessitate the use of the procedure.

The therapeutic exercises and therapeutic activities were medically necessary from 08/11/03 through 09/03/03 however physical therapy re-evaluation for dates of service 06/04/03 through 09/04/03 were not medically necessary to treat this patient.

The electrical stimulation and hot/cold packs were not medically necessary from 08/11/03 through 09/03/03. The medical records reviewed contained no evidence in the progress notes to indicate that any of the above-mentioned services were performed. As the services were undocumented, the services listed above were not medically necessary.

The use of the unlisted modality was not medically necessary from 08/27/03 through 09/03/03 as the protracted use of modalities after the first two to three weeks of care is not indicated in the post-surgical management of patients.

Sincerely,

Attachment

#### **Information Submitted to TMF for TWCC Review**

**Patient Name:**

**TWCC ID #: M5-04-1670-01**

#### **Information Submitted by Requestor:**

- Letter from Buckner Back and Neck Clinic
- Peer review letters
- Chiropractic Modality reviews
- Letters from insurance carrier
- Rebuttal letters from provider
- Diagnostic testing reports
- Physician examination reports
- Chiropractic daily SOAP notes
- Physical Therapy daily SOAP notes

#### **Information Submitted by Respondent:**

None