

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 February 17, 2004.

Based on correspondence received from the requestor, First Rio Valley Medical, P.A., dated, 08-11-04, dates of service 09-29-03 and 10-16-03 for CPT code 99080-73 have been withdrawn.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. 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 the only issue** to be resolved. The CPT 99214 for 09-29-03 **was found** to be medically necessary. The CPT 99214 for date of service 10-16-03, CPT 99212, 99213, 97110 and 97124 for dates of service 10-20-03 and 10-22-03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 dates of service 09-29-03 for CPT 99214 and 10-16-03 through 10-22-03 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 Order is hereby issued this 18<sup>th</sup> day of August 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division  
PR/pr

#### NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** May 11, 2004

**AMENDED DECISION**

**MDR Tracking #:** M5-04-1756-01  
**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**

The claimant apparently injured her cervical, right shoulder and lumbar region, due to the work related injury on \_\_\_.

The claimant originally sought treatment at \_\_\_ on that same date, per the two treatment notes dated 5/09/03 and 5/13/03.

The initial exam report dated 5/12/03 by \_\_\_ states impressions of an acute sprain/strain injury to the cervical and lumbar spine and possible herniated nucleus pulposus (HNP) to the lumbar spine. The initial diagnosis of (1) possible displacement of lumbar disc, (2) neck sprain, (3) lumbar sprain and (4) shoulder sprain/strain. Treatment plan, inclusive of physical medicine modalities, to cervical and lumbar spine, daily for 2 weeks, then at 3 times a week for an additional 5 weeks, pending improvement.

An MRI of the lumbar spine was performed on 6/20/03 revealing; central disc protrusion 3mm with ventral narrowing of the epidural fat and contact with the ventral aspect of the thecal sac lateral recess are patent bilaterally. (MRI's of the cervical spine and right shoulder were performed on that same date, however, no report was available for this review). Per report by \_\_\_ dated 10/16/03, reference to the cervical MRI revealed a 2.5 to 3mm central posterior disc herniation at C5-C6 and the right shoulder MRI was relatively unremarkable. Both cervical and lumbar MRI's revealed degenerative findings, associated with these disc conditions.

A referral for pain management was scheduled and a consultation was performed on 6/26/03 by \_\_\_, with pain management follow up visit reports available for review dated 7/03/03 and 8/22/03, reporting diagnosis as (1) lumbar facet dysfunction, (2) lumbar intervertebral disc displacement, (3) lumbar radiculopathy, (4) cervical intervertebral disc displacement, (5) cervical facet dysfunction and (6) right scapulocostal syndrome. Plan and recommendations inclusive of; physical therapy, bilateral lumbar radiofrequency ablation, trigger point injections to right shoulder region and pain and anti-inflammatory medications.

TWCC-73 dated 9/29/03 and 10/16/03 denoted return to work (RTW) with restrictions until 10/16/03, with re-evaluation scheduled in four weeks and possible future FCE.

Finally, the interim reports dated 10/16/03 and 11/13/03 by \_\_\_ demonstrated some range of motion (ROM) increases, however, pain remained relatively stable.

No further treatment/progress notes were available for this review beyond the interim report dated 11/13/03 by \_\_\_\_.

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

Please review and address the medical necessity of the outpatient services to include office visits (CPT 99214, 99212, 99213), therapeutic exercises (CPT 97110) and massage therapy (CPT 97124) reflecting dates of service 9/29/03 thru 10/22/03 for the above mentioned claimant.

### **Decision**

I disagree with the insurance company and find that CPT 99214 was medically necessary for date of service 9/29/03.

I agree with the insurance company and find that CPT 99214 for date of service 10/16/03, CPT 99212, 99213, 97110 and 97124 for dates of service 10/20/03 and 10/22/03 were not medically necessary.

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

This claimant has had the benefit of an appropriate and lengthy course of chiropractic therapy since the date of injury (DOI) on \_\_\_\_\_. Diagnostic findings do not hint at acute traumatic injury with pre-existing degenerative conditions for the most part. Nerve root compromise was not an issue and varying degrees of herniation were reported (dependent on who the reader was), however, correlating objective findings of what was available for review, were minimal for increased severity, in this case. No other diagnostics were available to correlate or verify any of the subjective radiculopathy complaints. The claimant had previous lumbar injury(s) to what extent, is unknown, as is, continued complaints pre-injury of DOI. Assuming that this claimant was involved with active type therapies in the initial trial period (first 6-8 weeks) and during times when injection events were performed, the necessity to continue another involved program, almost 5 months post injury, does not appear reasonable in light of continued subjective pain complaints at a visual analog scale (VAS) of 4 without any significant improvement, both past and present. Granted, the doctor does report some degree of increased ROM on selected movements, however, these are not that significant to warrant such an involved program that could have been attained in a less intensive setting, in my opinion. One would also speculate, given the claimant's physical make-up, that ROM probably would not be within normal limits on certain movements, especially lumbar, involving degenerative conditions and past injury. Pain can also be a limiting factor as mentioned earlier demonstrating no real improvement. It is also difficult to ascertain how this claimant was reported to make 100% strength gains in certain categories between, only a one visit interval (10/20/03 to 10/22/03), where previous therapy (over 4 months), apparently did not.

There were no available ROM reports, exam findings, or treatment notes corresponding to the right shoulder region, making this area non-reviewable and therefore, non-supportive of continued treatment. It is very clear in the TWCC Spine and Extremity Treatment Guideline,\* stating that it is the treating doctor's responsibility to provide documentary evidence of support to demonstrate that treatment is or was necessary. I did not find any reports on how these ROM's were arrived at, instrumental or visual inspection, since all areas were mainly within factors of 5.

Again, without increased severity findings this case appears to be accurately diagnosed as a mild-moderate sprain/strain to cervical and lumbar regions with questionable shoulder involvement (no diagnostic abnormal findings were present), complicated by apparently, pre-existing degenerative conditions.

Up thru 9/29/03, this claimant has experienced, supposedly, at least 16+ weeks of chiropractic therapy. It is known from most publicized literature and research articles including, TWCC Spine and Extremity Treatment Guideline\*, used as a reference, Waddell, G. Back Pain Revolution; Radebold, A., MD Lumbosacral Spine Strain/Sprain Injuries, to name a few, that most strain/sprain injuries lacking diagnostic severity will recover within 6-8 weeks with or without treatment.

It does appear the continuing subjective complaints may, in fact, be due to complicating pre-existing findings, verified by MRI, rather than the strain/sprain injuries.

Concerning office visits- CPT 99214; Re-examination should be limited to every 30 days. CPT 99214 was documented for dates of service (DOS) 9/29/03 and 10/16/03. No necessity was demonstrated for DOS 10/16/03 to be performed within the minimum 30 day cycle (i.e. a definitive change in the claimant's condition) and is therefore not reasonable or necessary.

CPT 99212 and 99213 was documented for DOS 10/20/03 and 10/22/03. For re-evaluation purpose this should not be scheduled more often than once every two weeks. However, since CPT 97110 and 97124 were not determined to be medically necessary then this code would also not be necessary.

CPT 97110; The necessity for continued active therapy in this intensive setting is not established for medically necessary, in regards to the aforementioned rationale.

CPT 97124; Likewise, this passive modality may have been beneficial early on however, in light of lack of documented muscle spasms, trigger points, etc. it's use this late in the treatment plan does not demonstrate efficacy over active movements, such as a home exercise program for pain relief.

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\*Even though the TWCC Spine and Extremity Treatment Guidelines have been abolished, it still remains a reliable reference source to provide guidance, regarding the necessity of treatment.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 11<sup>th</sup> day of May 2004.