

MDR Tracking Number: M5-04-2136-01

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 March 15, 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 the CPT Codes 99215-MP, 99214-MP, 99213-MP, 97265, 97110, 97530, and 97032 for dates of service 03/17/03 through 06/09/03 and 06/20/03 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.

According to the TWCC database the respondent received their copy of the Medical Dispute Resolution Request on March 18, 2004.

On May 25, 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.

Per Rule 133.307(e)(2)(B) the requestor has not provided convincing evidence of the carrier's receipt of the provider's request for EOBs for dates of service 03/21/03, 06/23/03, and 06/25/03 encompassing CPT Codes 99213-MP, 97265, 97110, and 97530; therefore, reimbursement is not recommended.

- CPT Code 99080-73 for date of service 06/13/03 denied as "U". In accordance with Rule 129.5 the Work Status Report is a Commission required report and is not subject to an IRO Review. Therefore, per Rule 133.106(f)(1) reimbursement in the amount of \$15.00 is recommended.

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 the amount of \$15.00 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 06/13/03 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 17th day of November 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 5/28/04

TWCC Case Number:	
MDR Tracking Number:	M5-04-2136-01
Name of Patient:	
Name of URA/Payer:	Reyna Moore, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician:	Reyna Moore, DC
(Treating or Requesting)	

May 11, 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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Rosalinda Lopez, Texas Workers Compensation Commission

CLINICAL HISTORY

Available information suggests that this patient reports experiencing a thoracic, rib, chest and lumbar injury that occurred while at work on _____. He presented initially to Reyna Moore, DC, on or about 12/09/02. No initial chiropractic examination notes are provided for review. Thoracic and lumbar MRIs were apparently performed and found essentially unremarkable for acute disorders. Some congenital lumbar stenosis and degenerative disc changes were noted. Chiropractic report of 01/30/03 suggests that he patient is diagnosed with lumbar, thoracic and rib sprain/strain with non-specific chest trauma. The patient is provided with multiple units of active and passive physical therapy modalities at 3x per week for 4 weeks. Additional chiropractic reports are submitted 02/24/03, 03/24/03, and 04/23/03 with essentially the same information. These follow-up reports do suggest that patient's pain has improved with medication and that some increase in range of motion is noted with active rehab. As of 03/05/03, the patient is referred to a physical therapist for additional modalities and therapeutic procedures. The patient is seen by a physician's assistant Amanda Fischer, PA-C, for trigger point injections on 03/27/03. Conditions at this time appear limited to degenerative disc disease and lumbar muscle spasms. The patient

undergoes ROM and muscle testing with another chiropractor on 06/09/03. The patient appears to have been referred for pain medicine evaluation with a Dr. Shay and surgical evaluation with a Dr. Murphy but reports of these evaluations are not provided for review.

REQUESTED SERVICE(S)

Determine medical necessity for office visits (99215), office visits w/manipulation (99213-MP), office visit (99214-MP), manual therapy tech. (97265/97140), electric stimulation (97032), therapeutic exercises (97110), myofascial release (97250) and therapeutic activities (97530) for the period in dispute 03/17/03 through 06/20/03

DECISION

Medical necessity for these ongoing treatments and services (03/17/03 through 06/20/03) **are not supported** by available documentation.

RATIONALE/BASIS FOR DECISION

Ongoing therapeutic modalities of this nature suggest little potential for further restoration of function or resolution of symptoms given the nature of injuries reported and diagnosed. There is little convincing data in the available literature supporting level, frequency and duration of these physical therapy applications, for sprain/strain conditions superimposed in existing congenital and degenerative back disorders. Office visit evaluations (99215) require comprehensive history, examination and medical decision making of high complexity. Available chiropractic reporting does not support this level of service. In addition, chiropractic office visits (99213-MP) require the application of "manipulation" as a management component. Though joint mobilization is documented as a separate service, there is no documentation of manipulation has been performed.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. *J Manipulative Physiol Ther* 2002; 25(1):10-20.
3. Bigos S., et. al., AHCP, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" [*Journal of Family Practice*](#), Dec, 2002.

5. Morton JE. Manipulation in the treatment of acute low back pain. *J Man Manip Ther* 1999; 7(4):182-189.
6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.
7. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.