

MDR Tracking Number: M5-04-2180-01

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 03-17-04.

The IRO reviewed office visits, therapeutic exercise, ultrasound, mechanical traction, myofascial release, chiropractic manual treatment-spinal, massage therapy, manual therapy and neuromuscular re-education rendered from 04-09-03 through 01-06-04 that were denied based upon "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.

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 06-22-04, 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 97110 for dates of service 03-19-03 through 10-30-03 (20 DOS), CPT code 99213 for dates of service 03-19-03 through 08-26-03 (16 DOS), CPT code 97035 for dates of service 03-19-03 through 07-07-03 (5 DOS), CPT code 97014 for date of service 03-19-03, CPT code 97250 for dates of service 03-21-03 through 07-21-03 (15 DOS), CPT code 97012 for dates of service 03-24-03 through 08-21-03 (5 DOS), CPT code 98940 for dates of service 08-21-03, 08-26-03 and 08-28-03, CPT code 97535 for date of service 08-28-03 and CPT code 97112 for date of service 08-28-03 all denied with denial code "D" (duplicate). The Medical Review Division cannot determine the original reason for denial of all these services and therefore no reimbursement is recommended.

This Findings and Decision is hereby issued this 27th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO decision

June 17, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Corrected items in dispute.

Re: Medical Dispute Resolution
MDR #: M5-04-2180-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: physical therapy notes, office notes, radiology reports, designated doctor exam.

Information provided by Respondent: office notes, physical therapy notes, radiology report, designated doctor exam.

Clinical History:

The claimant developed pain in the low back and leg following a work-related injury on _____. He presented for examination on/about 02/12/03. MR imaging of the lumbar

spine on 02/12/03 reveal L3/4 left far lateral subligamentous disc herniation, left far lateral L4/5 disc herniation, prominent epidural lipomatosis of L3-S1 creating stenosis/compression on the thecal sack, and facet hypertrophy with effusion to the zygapophyseal joints L3/4, L4/5, L5/S1. Claimant was treated on over 45 sessions with conservative chiropractic/physical therapy applications from 04/09/03 through 01/06/04, with the exception of the following dates of service: 04/25, 05/07-05/14, 05/28-05/30, 07/07-07/21, 08/21-08/28, and 10/30-12/30/2003.

Disputed Services:

Office visits, therapeutic exercise, ultrasound, mechanical traction, myofascial release, chiro man treatment-spinal, massage therapy, manual therapy, and neuromuscular re-education during the period of 04/09/03 through 01/06/04.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

The rationale of the provider to continue to implement non-disciplinary passive chiropractic/physical therapy applications as opposed to continuing with the behavioral algorithm identified in the 03/02/03 evaluation is not clear. In the 03/02/03 evaluation, a recommendation was made for referral to Texas Pain Solutions for evaluation and pain medication management. Identical recommendation was made on 05/14/03, 07/02/03, 08/26/03, and 01/26/04. Record reflects the continued proposed referral of this claimant, but no data reviewed supports an evaluation of the claimant occurred. There exist no qualitative/quantitative data to support the provider's continued application of passive, non-disciplinary applications in the management of this claimant's condition on over 45 sessions from 04/09/03 though 01/06/04. Further, there exists no efficacy for the provider's application of passive chiropractic physical therapy applications that include therapeutic exercise, ultrasound therapy, mechanical traction, myofascial release, chiropractic manual treatment-spinal, massage therapy, manual therapy, or manual muscular reeducation in the management of this claimant. The aforementioned information has been taking from the following guidelines of clinical practice and/or peer reviewed references:

Karjalainen, K., et al. *Multidisciplinary, Biocycle Social Rehabilitation for Subacute Low Back Pain Among Working Age Adults*. Cochran Database Syst. Rev. 2003; (2): CD002193.

Overview of Implementation of Outcome Assessment Case Management in a Clinical Practice. Washington State Chiropractic Association; 2001. 54 patient.

Unremitting Low Back Pain: North American Spine Society Phase III Guidelines for Multidisciplinary Spine Care Specialists. North American Spine Society. 2000 96 patient.