

MDR Tracking Number: M5-04-2812-01

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 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 April 30, 2004.

The 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 office visit, joint mobilization, myofascial release, massages therapy, chiropractic manipulative treatment, chiropractic manipulative treatment, and mechanical treatment rendered on 5/1/03 through 1/6/04 were not found to be 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.

On August 29, 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 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	MAR	EOB Denial Code	RATIONALE
5/1/03	97250	\$43.00	\$0.00	\$43.00	F	Review of the office note submitted for review supports delivery of service, the requestor is therefore entitled to reimbursement in the amount of \$43.00.
7/8/03	99213	\$50.00	\$0.00	\$48.00	N	The office note submitted for review meets the documentation criteria required for CPT code 99213. The requestor is therefore entitled to reimbursement in the amount of \$48.00.
	97265	\$43.00	\$0.00	\$43.00	N	The office note submitted for review meets the documentation criteria required for CPT code 97265. The requestor is therefore entitled to reimbursement in the amount of \$43.00.
	97250	\$43.00	\$0.00	\$43.00	N	The office note submitted for review meets the documentation criteria required for CPT code 97250. The requestor is therefore entitled to reimbursement in the amount of \$43.00.
TOTAL		\$179.00	\$0.00	\$177.00		Reimbursement is recommended in the amount of \$177.00.

ORDER

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 rendered on 5/1/03 through 7/8/03 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 8th day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 1, 2004

RE:

MDR Tracking #: M5-04-2812-01

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.

General Documentation Provided for Review:

- Table of disputed services
- Explanation of benefits for the disputed dates of service

- Diagnoses were listed to be neck sprain/strain, lumbar sprain/strain, rotator cuff syndrome and other symptoms referable to back probably lumbar facet syndrome.

Submitted by Requester:

- Cover letter from _____ explaining the packet of submitted documentation.
- Multiple daily chiropractic notes consisting of approximately 59 chiropractic visits from 7/16/02 through 3/31/03.
- Daily chiropractic notes of 5/1/03, 5/14/03, 6/2/03, 7/8/03, 8/5/03, 9/11/03, 10/13/03, 10/21/03, 11/14/03, 11/19/03, 12/12/03 and 1/16/04.
- Initial medical narrative report from the treating chiropractor dated 7/16/02.
- Subsequent medical chiropractic report of 8/6/02
- Cervical range of motion reports of 8/6/02, 9/24/02 and 12/4/02.
- Lumbar range of motion studies of 8/6/02, 9/24/02 and 12/4/02
- Left shoulder range of motion studies of 8/6/02, 9/24/02 and 12/4/02.
- Subsequent chiropractic report of 12/4/02.
- Muscle strength testing documentation of 8/8/02, 8/27/02, 9/18/02, and 10/16/02 involving the upper extremity and cervical spine.
- Muscle strength testing documentation of 8/8/02, 8/27/02. 9/18/02 and 10/16/02 involving the lower extremity and lumbar spine.

Submitted by Respondent:

- Medical business management services note or report of 6/16/04 explaining why the disputed dates of service were not reasonable or medically necessary.
- Thirteen physical therapy visits (one was a cancelation) from February through March 2002, prior to the chiropractic visits.
- A peer review report from _____ dated 4/6/04.
- Benefit review conference and contested case hearing documentation of 4/7/04 and 5/14/04. The issue at hand was whether or not the lumbar spine was considered compensable and the decision and order appeared to be in favor of the carrier in that the lumbar spine was found not to be compensable and the ___ injury extended to only strains of the left arm, left shoulder, neck and left groin.
- Cervical spine x-ray reports
- Report/narrative from _____, neurologist, of 8/26/02.
- Needle EMG study of the left upper extremity of 8/26/02 from _____ which was read as normal.
- A report or note from _____ and _____ of 1/28/02.
- Physical therapy follow up note of 3/14/02.
- Multiple physical therapy/treatment notes dated 2/15/02 through 3/14/02 for a total of 12 visits.
- TWCC-69 report from _____ indicating the claimant was at MMI as of 5/9/02 with 0% impairment rating.
- An impairment rating report/narrative from _____ of 5/9/02.

- A change of treating physicians form of 7/3/02 indicating the claimant wanted to change treating physicians to _____.
- Letter from the claimant dated 6/25/02 that was handwritten indicating that he was still in pain and wanted to change treating physicians.
- An initial chiropractic evaluation of 7/16/02.
- Subsequent chiropractic report of 8/6/02 as well as 9/24/02.
- TWCC-73 form from _____ indicating the claimant could return to work without restrictions as of 8/8/02.
- Multiple cervical, lumbar and left shoulder range of motion reports of 8/6/02, 9/24/02, and 12/4/02.
- Subsequent chiropractic report of 12/4/02.
- Multiple chiropractic daily notes dated 1/7/03, 1/10/03, 2/21/03 and 3/31/03.

Clinical History

It appears the claimant was working as a plumber and while crawling on a rotted out sub-floor, the floor gave way causing him to fall a reported 5-7 feet. The claimant reportedly struck the left side of his neck and upper shoulder during the impact. There has been some controversy regarding whether or not the claimant had lumbar spine involvement. The documentation revealed the claimant did not start complaining of low back pain until about 3/11/02. A note from _____ of 3/14/02 states that "Also of note is the fact that the claimant has experiencing low back pain since 3/11/02. He is unsure of the etiology of this; however, does not feel it is related to his work injury or exercise program performed here." At the time of the impairment rating of 5/9/02 the claimant was reporting only off and on discomfort in the left side of his neck area. The examination findings were essentially normal. The subjective complaints actually seemed to exceed that of the objective findings. The documentation provided for review indicates that the claimant received about 59 chiropractic visits from 7/16/03 through 3/31/03 and then the disputed dates of service began on 5/1/03, which was the next visit following 3/31/03. There were a few cancelations during the 59 chiropractic visits, therefore this number is not exact and probably ranges in actuality from 50-59 visits. The claimant also collapsed at work sometime in late October 2002 and he was taken to the hospital. This turned out to be what was documented to be an inner ear problem that was causing some dizziness. This was obviously not work related. The complaints at the chiropractic office were documented to be much more voluminous than previously mentioned at _____ office. The claimant's initial pain scale was noted to be a 5/10 at the chiropractic visit of 7/17/02, yet the pain scale quickly dropped by the end of July and first of August to a 3/10 pain scale and essentially remained at this level throughout the rest of the documentation. _____ documented the presence of moderately severe spasms and trigger points and decreased range of motion which in no way correlated with the findings of _____ or the initial physical therapy notes through May 2002. According to the chiropractic documentation of 10/9/02 the claimant underwent a designated doctor evaluation on 10/8/02 and was given a 5% whole person impairment rating. Again, this was the statement of 10/9/02 and there is no such report provided for review. The claimant also underwent a lumbar MRI and this revealed only the presence of pre-existing degenerative changes and facet arthrosis in the usual expected places given the claimant's age of 55 years. During the disputed dates of service it was noted that the claimant's pain levels upon entering the office beginning on 5/1/03 were around a 2-3/10 as they had been since late July and early August 2002. The multiple range of motion and strength evaluations from the chiropractor through December 2002 indicated some progression in the claimant's strength and range of

motion. It should be noted that when the claimant saw _____ in August 2002 the claimant's shoulder range of motion was reported as normal and the claimant was completely neurologically intact.

Requested Service(s)

Office visits (99213/99212-25/99211-25/99213-25), joint mobilization (97265, myofascial release (97250), massage therapy (97124), chiropractic manipulative treatment spinal 1 to 2 regions (98940), CMIT spinal 3 to 4 regions (98941), mechanical traction (97012) for the dates of service of 5/1/03 through 1/16/04. Denied by Carrier for medical necessity with "U" code. These disputed dates of service include 9 disputed dates of service which run from 5/1/03 through 1/16/04. These dates of service and the character of the treatment notes indicate that this was a maintenance type of plan and the care consisted only of passive modality treatment.

Decision

I agree with the insurance carrier and find that the services in dispute were not medically necessary.

Rationale/Basis for Decision

The submitted documentation from numerous sources as outlined above highly suggest that the ___ injury consisted of contusions and myofascial sprain/strain injuries to the neck and shoulder. There was no evidence at all of rotator cuff tears or involvement and there was no evidence of cervical or lumbar radiculopathy. On 8/26/02 _____, neurologist, documented that the claimant's shoulder range of motion was normal, shortly after the initiation of chiropractic management. In fact, _____ impressions consisted of "neck and left arm and low back pain of musculoskeletal origin". The documentation further revealed that the claimant had undergone 12 physical therapy visits while under the care of _____ and another 50-59 chiropractic visits occurred from 7/16/02 through 3/31/03 just prior to the beginning of the disputed dates of service. This amount of treatment far exceeds the treatment recommendations from the highly evidence based Official Disability Guidelines as well as from the ACOEM guidelines for the management of musculoskeletal sprain/strains and contusion injury. In fact these guidelines recommend about 18-24 visits maximum for management of this particular injury and, given the nature and scope of the documented injury, the treatment has far exceeded the guidelines recommendations. It should also be kept in mind that this claimant missed no work and his pain levels have essentially been the same since the beginning of August 2002. The services during the disputed dates of service consisted of a maintenance care program that consisted further of passive modality treatment only which would not be indicated well over a year post injury. The claimant's presenting pain levels during the disputed dates of service were minimal and occasional aches and pains associated with everyday work in a 55 year old plumber would not be considered related to the injury of ___ within a reasonable degree of medical certainty. Treatment of a work related injury, especially that of a myofascial sprain/strain injury without endpoints is not reasonable or medically necessary. The documentation also suggests that the claimant was found to be at MMI on 10/8/02 per a designated doctor evaluation, at least according to a 10/9/02 chiropractic note. If this were true, then this would be the second time the claimant was found to be at MMI prior to 10/9/02 and with minimal, if any, impairment. The documentation strongly suggests that the treatment has been overly excessive and a maintenance

care program would not be indicated given the nature and scope of the injuries which produced obvious minor impairment. The claimant should be transitioned completely into a home based exercise program. The current signs and symptoms are likely the result of the normal degenerative process in this 55 year old plumber and his occasional increases in pain are due to everyday work activities not associated with the ___ injury.