

MDR Tracking Number: M5-04-3307-01

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 06-01-04.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the 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.

The IRO reviewed office visits (with and without manipulation), group therapeutic procedures, myofascial release (i.e. manual therapy), ultrasound, hot/cold packs therapy, and therapeutic exercises rendered from 6/02/03 through 7/07/03 that was denied based upon "U." These services **were found** to be medically necessary.

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.

Per correspondence from the insurance carrier dated 6/22/04, reimbursement for services rendered on 6/2/03 was made to the requestor on 7/01/03 in the amount of \$111 (for CPT codes 97035, 97250, 97110, and 97010). The requestor confirmed that payment was received via telephone contact with Jo Schweizer on 9/07/04. Reimbursement was made in accordance with the Medical Fee Guidelines; therefore, the Medical Review Division will not address these items.

On July 13, 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.

In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service for CPT code 99213 (office visit) on date of

service 6/10/03. Reimbursement is recommended in the amount of \$48.00 in accordance with the Medical Fee Guidelines.

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 6/02/03 through 7/07/03 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 8th day of September 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

MEDICAL REVIEW OF TEXAS
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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3307-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

August 2, 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,

CLINICAL HISTORY

Available documentation received and included for review involved 57 pages of records from Drs. B (DC), K (DC), H (DO), F (MD) and Mssrs. C (OTR) and D (PA) including treatment and surgical notes, rehab notes, office visits.

Available record review reveals the following:

____, a 50-year-old female, sustained work-related complaints to her neck and upper extremities, apparently as a result of repetitive/overuse exposure to typing. Unfortunately, only part of the file is available for review and so it is a little difficult to determine exactly what has happened with this lady. It appears that she has a history of chronic neck pain secondary to HNP (X3) in the cervical spine, as well as pain and numbness to the bilateral upper extremities, right more so than left. She underwent extensive physical therapy since sometime in November 1999, to which she responded reasonably well. Apparently sometime in November 2002, she had a return / increase of pain and difficulty in the neck and upper extremities. She

had electrodiagnostics performed which were positive for bilateral carpal tunnel syndrome. She then had right sided carpal tunnel release surgery in April 2003 after steroid injections failed to provide permanent relief. She underwent post surgical rehab with an occupational therapist, however continued with difficulties to her neck and left side by June 2003. This included a trip to the emergency room at the end of May 2003. She continued with occupational therapy through June of 2003 along with some epidural steroid injections, which were helpful in alleviating her neck and left upper extremity pain.

REQUESTED SERVICE(S)

Medical necessity of office visits with manipulations and without, ultrasound, hot/cold packs, group therapeutic procedures, manual therapy and therapeutic exercises. 6/02/03-7/7/03.

DECISION

Approved. There is establishment of medical necessity for all procedures in the disputed timeframe.

RATIONALE/BASIS FOR DECISION

The patient was diagnosed with an overuse injury related to a 27-year-occupational history. These problems are notoriously difficult to contain, with associated complex neck-arm-hand syndromes, such as seen in this situation. It appeared that she suffered a fairly significant worsening/deviation from a baseline in her condition in ___ of ___. Treatment was resumed with an appropriate progression in levels of intervention to surgery, followed by course of post-surgical rehab. The patient had complicating cervicogenic involvement, consistent with her history of multiple disc herniations with susceptibility to retrograde irritation from the upper extremity problems. This was successfully dealt with by cervical ESI's.

The attempted forms of intervention were certainly will within standards of practice. There is good consistency and agreement regarding this patient's condition on all the attending providers. A focused post-surgical program is appropriate and was medically necessary. The medical necessity for all disputed procedures is well documented in the medical records.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later

date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

References:

1. Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".
2. Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;
3. Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.
4. Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140