

MDR Tracking Number: M5-04-3468-01

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 06-10-04.

The IRO reviewed electric stimulation, hot/cold pack therapy, therapeutic exercises, office visits, therapeutic procedures, neuromuscular re-education, manual therapy and chiropractic therapy rendered from 10-29-03 through 04-13-04 that were denied based upon "V".

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.

The IRO determined that the treatments and services beginning 11-11-03 through 01-19-04 (including PT assessment of 10-29-03) **were** necessary. The treatments and services provided from 01-20-04 through 04-13-04 **were not** found to be necessary. The respondent raised no other reasons for denying reimbursement for electric stimulation, hot/cold pack therapy, therapeutic exercises, office visits, therapeutic procedures, neuromuscular re-education, manual therapy and chiropractic therapy.

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 07-16-04, 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 99371 for date of service 02-17-04 denied with a G/B377 denial code (bundled procedure). Per Medical Fee Guideline 134.202(b) effective 08-01-03 this is an invalid code, therefore no reimbursement is recommended.

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 10-29-03 through 01-19-04 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 Findings and Decision and Order are hereby issued this 9th day of September 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 8/13/04

TWCC Case Number:	
MDR Tracking Number:	M5-04-3468-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

August 10, 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 information suggests that this patient reports an injury to her neck and back from a slip and fall accident that occurred at work on _____. The patient eventually had both cervical and lumbar surgery most recently as of 10/07/03. Attending neurosurgeon, Dr. M, MD, wrote an order for gentle physical therapy involving heat, massage, exercise and ROM on 11/11/03 at 3x per week for 6 weeks. His follow-up note on 01/19/04 indicates that the patient is much improved, no additional post-operative physical therapy is ordered, and the patient is released from care. The patient apparently began post-operative physical therapy and chiropractic treatment as early as 10/29/03 and it was continued with multiple active and passive modalities through 04/13/04. There appear to be multiple entries in chiropractic and physical therapy notes that the patient was returned for surgical follow up during this period, but no surgical follow-up notes or orders are found beyond 01/19/04.

REQUESTED SERVICE(S)

Determine medical necessity for Electric stimulation (97032), hot/cold therapy (97010), therapeutic exercise (97110), office visits (99213), therapeutic procedures (97150), neuromuscular re-education (97112) manual therapy (97140), and chiropractic therapy (98940P) for period in dispute 10/29/03 through 04/13/04.

DECISION

Medical necessity for these ongoing treatments and services prescribed for six weeks duration (per surgeon's order) beginning 11/11/03

through 01/19/04 (including PT assessment of 10/29/03) **are** reasonably supported by documentation.

All treatments and services provided from **01/20/04 to 04/13/04 are not supported** by available documentation or available surgeon's orders and are denied.

RATIONALE/BASIS FOR DECISION

Ongoing therapeutic modalities of this nature suggest little potential for further restoration of function or resolution of symptoms for post surgical patients at four years post injury. With available documentation suggesting pre-existing degenerative conditions, previous failure with conservative care and significant behavioral or psychosocial conditions, it would appear that these issues would need to be appropriately addressed, with medical/surgical consult, before beginning an extended course of treatment for reimbursable conditions of _____. In addition, there appears to be significant medical/surgical contraindications with regard to chiropractic manipulation and manual therapy for post surgical cervical spine conditions, not specifically addressed (see orders from Dr. M, MD, on 11/11/03 and follow-up note of 01/19/04).

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Powell FC, Hanigan WC, Olivero WC: A risk/benefit analysis of spinal manipulation therapy for relief of lumbar or cervical pain. *Neurosurgery* 1993; 33(1): 73-79.
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. Guidelines for Medically-based Outpatient Physical Therapy and Occupational Therapy for Post-Surgical Cervical Spine; HCFA, Pub 09, Rehabilitation Manual, HCFA., Pub 10, Outpatient Manual, Rehabilitation.
6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

7. Polkinghorn BS, Colloca CJ, *Chiropractic treatment of postsurgical neck syndrome with mechanical force, manually assisted short-lever spinal adjustments*, J Manipulative Physiol Ther. 2001 Nov-Dec; 24(9): 589-95.

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.