

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-2036.M5

MDR Tracking Number: M5-04-3925-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 7-16-04.

The IRO reviewed chiropractic manipulation, therapeutic exercises, manual therapy, and office visits on 12-8-03 to 1-8-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO concluded that the office visit on 12-15-03 was medically necessary. The IRO agreed with the previous determination that the chiropractic manipulation, therapeutic exercises, manual therapy, and office visits from 12-8-03 to 1-8-04 were not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 8-10-04, 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.

Codes 97140-59, 98940, and 99212-25 billed for date of service 9-5-03 were denied as "E" and upon reconsideration, the services were denied as "O – per 6-24-03, RME chiro treatment not R&N". The TWCC-21 on file states the carrier is disputing degenerative disk disease. The diagnosis codes on the bill do not include degenerative disk disease; therefore, these services will be reviewed per Rule 134.202.

- Code 97140-59 – MAR is $\$27.24 \times 125\% = \34.05 . Recommend reimbursement of \$34.05.
- 98940 – MAR is $\$26.46 \times 125\% = \33.08 . Recommend reimbursement of \$33.08.
- Code 99212-25 – MAR is $\$37.78 \times 125\% = \47.23 . Recommend reimbursement of \$47.23.

Code 99080-73 billed for dates of service 1-5-04 and 1-8-04 were denied as unnecessary medical. The TWCC-73 is a required report and not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; therefore, recommend reimbursement.

- Code 99080-73 – Per Rule 129.5, the MAR is \$15.00. Recommend reimbursement of $\$15.00 \times 2 = \30.00 .

Code 99212 billed for date of service 1-20-04 was denied as "F" and the carrier paid \$47.23. The MAR is \$37.78 x 125% = \$47.23. The requestor is seeking an additional \$1.76. No additional reimbursement is recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby **ORDERS** the respondent to pay for 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 for dates of service 9-5-03 to 1-8-04 in this dispute.

This Order is hereby issued this 8th day of October 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION - REVISION

Date: September 2, 2004

RE: MDR Tracking #: M5-04-3925-01
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 physician reviewer. The Chiropractic physician 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.

Submitted by Requester:

- Daily notes, narrative reports
- Examination reports
- FCE report
- Psychological reports

Submitted by Respondent:

- Daily notes
- Surgical notes
- FCE reports
- A peer review
- Psychological reports
- Designated doctor reports

Clinical History

According to the supplied documentation, it appears that the claimant sustained an injury on ___ when she was unloading boxes at work. She reported low back pain. The claimant underwent chiropractic therapy and lumbar epidural steroid injections. MRI reports were discussed, but not included in the supplied material. A NCV/EMG study performed on 01/27/2003 revealed no abnormalities. Chiropractic therapy continued. Medical evaluations continued. The claimant underwent an IDET procedure on 09/22/2003. A FCE performed on 11/24/2003 revealed that the claimant was at a sedentary level, while her job required her to be a medium PDL. The claimant was seen by ___ on 11/25/2003 who reported that she was post-IDET, had 2 levels of disc displacement, chronic back pain and lumbar radiculopathy. Therapy was reviewed for the dates in question. Documentation was submitted for therapy beyond the dates in question, but was not reviewed.

Requested Service(s)

Please review and address the medical necessity of the outpatient services rendered between 12/08/2003 – 01/08/2004 including CMT (98940), therapeutic exercises (97110), manual therapy (97140) and office visits (99212 and 99213).

Decision

I disagree with the insurance company and agree with the treating doctor that the office visit dated 12/15/2003 (99212 only) was medically necessary. I agree with the insurance company that the remainder of the therapy was not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, the claimant has had a plethora of treatment. The claimant has undergone conservative therapy, medical treatment, surgical treatment and psychological treatment. The therapy in question is over one year post injury. The claimant had an IDET procedure performed on 09/22/2003. After the claimant was released to therapy, a short term of therapy lasting approximately 4 weeks is seen as reasonable and necessary. Since this claimant had had an extensive amount of therapy, ongoing and redundant care is not seen as necessary. With over one year of therapy with the treating doctor, the claimant would be well versed in active therapies that would continue to improve her symptoms. Continued one on one therapy protocols is not considered appropriate to treat the compensable injuries and would more likely induce potential doctor dependence. Monthly office visits are seen as necessary to continue to monitor progress and refer as needed.