

MDR Tracking Number: M5-04-4307-01

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 July 29, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The chiropractic manipulations (98940 & 98941) on 08-04-03, 08-06-03, 08-20-03, 08-22-03 and 08-27-03 were found to be medically necessary. The office visits, aquatic therapy, mechanical traction and electrodes from 08-01-03 through 10-09-03 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. Therefore, the requestor is not entitled to reimbursement of the 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 September 16, 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 129.5, the requestor submitted relevant information to support delivery of service for CPT code 99080-73 on date of service 08-26-03. The carrier denied this service for unnecessary medical treatment based on a peer review however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and therefore, recommends reimbursement in the amount of \$15.00 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 08-04-03 through 08-27-03 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 15th day of October 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr
Enclosure: IRO decision

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 10/12/04

TWCC Case Number:	
MDR Tracking Number:	M5-04-4307-01
Name of Patient:	
Name of URA/Payer:	East Texas Chiropractic
Name of Provider: (ER, Hospital, or Other Facility)	East Texas Chiropractic
Name of Physician: (Treating or Requesting)	R. Keith Calda, DC

September 30, 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,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

REVISED 10/12/04

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Correspondence and medical records from the treating doctor
2. Correspondence from the carrier's attorney
3. EOB's from the carrier
4. Designated doctor's report
5. Diagnostic imaging reports
6. ESI operative report
7. Required medical examination

Patient underwent examinations, diagnostic imaging, physical medicine treatments and ESI after injuring his low back while slipping and falling at work on ____.

REQUESTED SERVICE(S)

Office visits, chiropractic manipulation, 97113-aquatic therapy, 97012-mechanical traction and A4556-electrodes from 08/1/03 through 10/09/03.

DECISION

The manipulations (98940 and 98941) performed on 08/04/03, 08/06/03, 08/20/03, 08/22/03 and 08/27/03 are approved. All other services and treatments are denied.

RATIONALE/BASIS FOR DECISION

According to the AHCPR¹ guidelines, spinal manipulation is the only recommended treatment that can relieve symptoms, increase function and hasten recovery for adults suffering from acute low back pain. Based on those findings (and since the records do not reveal if spinal manipulation had been performed prior to 08/01/03), a regimen of this recommended form of treatment (98940 and 98941) was indicated and was performed during the month August 2003. (Based on the progress notes,

¹ Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.

manipulation was not performed on 08/01/03 so that DOS is denied.)

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters*² Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." The ACOEM Guidelines³ state that if manipulation does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated.

Continued treatment after the 4-week period was not indicated since the patient did not respond to care as evidenced by his essentially unchanged pain ratings of 7/10 on 08/01/03 and 6/10 on 08/27/03. The disputed treatment did not fulfill statutory requirements⁴ for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to employment. Specifically, the patient's pain was 7/10 on 08/01/03 at the initiation of the disputed treatment, 6/10 on 09/02/03 and remained at 6/10 on 10/09/03 at the termination of the disputed treatment. Therefore, the medical necessity for all treatment after 08/27/03 is not supported.

² Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.

³ ACOEM *Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers*, 2nd Edition, p. 299.

⁴ Texas Labor Code 408.021