

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

**SOAH DOCKET NO. 453-05-3188.M5**

MDR Tracking Number: M5-05-0006-01

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 August 30, 2004.

The Medical Review 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 chiropractic manipulative treatment, manual therapy, ultrasound therapy, electrical stimulation, office visits, work conditioning and work conditioning, each additional hour were not 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 September 22, 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 19 days of the requestor's receipt of the Notice.

- CPT Code 98940 for dates of service 09/24/03 and 10/02/03 denied as "G". The carrier did not specify which code 98940 is global to per Rules 133.304 (c) and 134.202(a)(4); therefore, reimbursement in the amount of \$60.28 ( $\$24.11 \times 125\% = \$30.14 \times 2$ ) is recommended.
- CPT Code 97140 (3 units total) for dates of service 09/26/03 through 10/09/03 denied as "G". Per Rules 133.304 (c) and 134.202(a)(4) the carrier did not specify which code 98940 is global to; therefore, reimbursement in the amount of \$92.70 ( $\$24.72 \times 125\% = \$30.90 \times 3$ ) is recommended.
- CPT Code 97035 for date of service 10/16/03 denied as "D". The carrier has not submitted convincing evidence that this CPT code is a duplicate billing. Per Rule 134.202(c)(1) reimbursement in the amount of \$14.21 ( $\$11.37 \times 125\%$ ) is recommended.
- CPT Code G0283 for date of service 10/16/03 denied as "D". The carrier has not submitted convincing evidence that this CPT code is a duplicate billing. Per Rule 134.202(c)(1) reimbursement in the amount of \$14.91 ( $\$11.93 \times 125\%$ ) is recommended.
- CPT Code 99205 for date of service 11/18/03 denied as "L". Per Rule 126.9 the requestor has not submitted any relevant information to dispute the carrier's denial. Reimbursement is not recommended.
- CPT Code 99080-73 for date of service 11/24/03 denied as "V". Per Rule 129.5 the TWCC-73 is a required report and MDR has jurisdiction in this matter. Per Rule 133.106(f)(1) reimbursement in the amount of \$15.00 is recommended.
- CPT Code 99214 for date of service 12/11/03 denied as "G". Per Rules 133.304 (c) and 134.202(a)(4) the carrier did not specify which code 99214 is global to; therefore, reimbursement in the amount of \$92.30 ( $\$73.84 \times 125\%$ ) is recommended.

- CPT Code 99213 for date of service 12/22/03. EOBs were not submitted by either party; therefore, this date of service will be reviewed according to Rule 134.202 and the Medicare Fee Schedule. Per Rule 134.202(c) reimbursement in the amount of \$59.00 (\$47.20 x 125%) is recommended.
- CPT Code 98940 for date of service 01/30/04 denied as "G". Per Rules 133.304 (c) and 134.202(a)(4) the carrier did not specify which code 99214 is global to; therefore, reimbursement in the amount of \$31.35 (\$25.08 x 125%) is recommended.
- CPT Code 99211 for date of service 03/02/04 denied as "D". The carrier has not submitted convincing evidence that this CPT code is a duplicate billing. Per Rule 134.202(c)(1) reimbursement in the amount of \$24.44 (\$19.55 x 125%) is recommended.

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 outlined above as follows:

- In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- In accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);
- 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 date of service 09/24/03 through 03/02/04 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 Decision and Order is hereby issued this 4<sup>th</sup> day of November 2004.

Marguerite Foster  
 Medical Dispute Resolution Officer  
 Medical Review Division

MF/mf

NOTICE OF INDEPENDENT REVIEW DECISION

October 27, 2004

Program Administrator  
 Medical Review Division  
 Texas Workers Compensation Commission  
 7551 Metro Center Drive, Suite 100, MS 48  
 Austin, TX 78744-1609

RE: Injured Worker:  
 MDR Tracking #: M5-05-0006-01  
 IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional 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 TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

#### Clinical History

This 21 year-old male patient had a sudden onset of low to mid back pain on \_\_\_ while lifting a trash container at work. His treatment for a diagnosis of thoracolumbar strain includes medication, physical therapy, chiropractic modalities beginning 09/10/03, trigger point injections, and work conditioning from 01/12/04 through 02/06/04.

#### Requested Service(s)

Chiropractic manipulative treatments, manual therapy, ultrasound therapy, electrical stimulation, office visits, work conditioning, and work conditioning each additional hour for dates of service 10/15/03 through 03/10/04

#### Decision

It is determined that there is no medical necessity for the chiropractic manipulative treatments, manual therapy, ultrasound therapy, electrical stimulation, office visits, work conditioning, and work conditioning each additional hour for dates of service 10/15/03 through 03/10/04 to treat this patient's medical condition.

#### Rationale/Basis for Decision

Medical record documentation does not indicate the necessity for chiropractic manipulative treatments, manual therapy, ultrasound therapy, electrical stimulation, and office visits to treat this patient's medical condition. Further, there is no medical indication for a transition to work program like work conditioning while treating within the strain/sprain therapeutic algorithm. An initial controlled trial of 10-12 sessions over a 4-week duration was appropriate and no further application beyond the providers initial controlled trial is warranted. There is no medical data that establishes efficacy to warrant management of this patient's thoracic/lumbar strain/sprain injury beyond \_\_\_. Therefore, the chiropractic manipulative treatments, manual therapy, ultrasound therapy, electrical stimulation, office visits, work conditioning, and work conditioning each additional hour for dates of service 10/15/03 through 03/10/04 were not medically necessary to treat this patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID#: M5-05-0006-01

Information Submitted by Requestor:

- Appeal letter
- Office notes
- Daily therapy progress notes
- Work hardening daily progress notes
- Designated doctor evaluation
- MMI evaluation
- PPE
- Functional capacity evaluation
- MRI report

Information Submitted by Respondent:

- Peer review
- Physician office notes
- Treatment notes