

MDR Tracking Number: M5-05-0038-01

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 8/30/04. Dates of service prior to 8/30/03 are untimely filed and per Rule 133.308 (e)(1) not eligible for review.

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 electrical stimulation, therapeutic exercises, manual therapy, office visits, hot/cold pack therapy, DME, ultrasound therapy, and analysis of data 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 9/27/04, 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. The Requestor submitted an updated Table of Disputed Services on 1/13/05 and 1/14/05.

**CPT Code 99090 for date of service 9/25/03** – The Carrier denied reimbursement for services as “G – This is a bundled procedure; no separate payment allowed”. The Carrier did not state what service this was global to according to Rule 133.304(c). According to Rule 134.202(c)(6), for products or services for which CMS or the Commission does not establish a relative value unit and/or a payment amount the Carrier shall assign a relative value. The Carrier has not assigned a relative unit. The Requestor billed \$120.00. Reimbursement in the amount of \$120.00 is recommended.

**CPT Code 97545-WC and 97546-WC for dates of service 11/10/03 through 11/14/03** – The Carrier denied reimbursement for services as “F” MAR reduction and “A” Pre-Authorization not obtained. The Carrier has not made a reimbursement. The Requestor submitted documentation to support pre-authorization was given for work hardening but it failed to include work conditioning. On this basis, reimbursement is not recommended.

**CPT Code 99080-73 dates of service 1/22/04 and 4/05/04** – The Carrier denied reimbursement as “U - Unnecessary medical treatment or service”; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical

Review Division has jurisdiction in this matter. Therefore, reimbursement is recommended in the amount of \$30.00 (\$15.00 x 2).

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 Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c) and 134.202(a)(4);
- 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 9/25/03 through 4/05/03 as outlined above 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 14th day of January 2005.

Pat DeVries  
Medical Dispute Resolution Officer  
Medical Review Division

PRD/prd

Enclosure: IRO Decision

October 28, 2004

Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

Re: Medical Dispute Resolution  
MDR #: M5-05-0038-01  
TWCC#:  
Injured Employee:  
DOI:  
SS#:  
IRO Certificate No.: 5055

Dear

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in chiropractic and is currently on the TWCC Approved Doctor List.

### **REVIEWER'S REPORT**

#### **Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's  
Information provided by Requestor:

- Treatment notes 09/03/02 – 04/21/04
- Daily treatment logs & WH/WC evaluations 08/27/02 – 02/18/04
- Progress notes 11/18/02 – 10/01/03
- Impairment ratings 03/02/04 – 04/17/04
- Pre-authorizations 09/03/02 – 11/18/03
- FCE's and PPE 09/19/03 – 01/19/04
- Prescriptions 09/10/02 – 01/27/04
- Consultation notes and operative reports 12/09/02 – 02/05/04

Information provided by Respondent:

- Correspondence
- Chiropractic modality reviews 03/03/04 & revised 03/09/04
- Designated doctor exam 10/21/03
- Retrospective peer review 08/08/02

#### **Clinical History:**

The claimant initially reported a work-related low back injury to her employer on \_\_\_\_\_. The claimant received appropriate urgent medical services, exhaustive advanced invasive pain management services, and protracted chiropractic services. The claimant eventually underwent lumbar laminectomy and fusion. Subsequently, she was provided postoperative rehabilitative services by the treating chiropractor.

#### **Disputed Services:**

Electrical stimulation, therapeutic exercises, manual therapy, office visits, hot/cold pack therapy, DME, ultrasound therapy, and analysis of data stored information during the period of 09/02/03 thru 04/21/04

**Decision:**

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

**Rationale:**

The services performed on the dates in question were not substantiated as medically necessary services by the supportive clinical documentation submitted by the treating chiropractor. This position is upheld by evidence-based documentation, including The Official Disabilities Guidelines, which is a publication of The Work Loss Data Institute. The guidelines and recommendations published in this text are based on their analysis and interpretation of four U.S. Government databases.

Regarding the diagnosis of 722.8 post laminectomy syndrome, these guidelines propose the following chiropractic guidelines: 14-16 visits over 12 weeks.

Regarding the diagnosis 738.4, acquired spondylolisthesis, this text has no recommendation for chiropractic treatment. Furthermore, current peer-reviewed medical literature does not support chiropractic manipulative therapy as an effective mode of treatment for this diagnosis.