

MDR Tracking Number: M5-05-0950-01

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 11-22-04.

The IRO reviewed office visits, chiropractic manipulation, manual therapy, ultrasound therapy, electric stimulation and mechanical traction rendered from 12-29-03 through 01-13-04 that were denied based upon "U".

The IRO determined that the chiropractic manipulation (98941) **was not** necessary. The IRO determined that all other services (office visits, manual therapy, ultrasound therapy, electric stimulation and mechanical **were** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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

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 01-14-05, 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 99080-73 dates of service 12-29-03, 01-09-04 and 01-13-04 denied with denial code "U" (unnecessary medical without peer review). Per Rule 129.5 the TWCC-73 is a required report and is not subject to an IRO review. A referral will be made to the Compliance and Practices Division due to violation of Rule 129.5 by the carrier. Reimbursement is recommended in the amount of **\$45.00 (\$15.00 X 3 DOS)**.

### **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 Medicare program reimbursement methodologies effective 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 Decision is applicable for dates of service 12-29-03 through 01-13-04 in this dispute.

This Findings and Decision and Order are hereby issued this 11th day of February 2005.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-0950-01
Name of Patient:	
Name of URA/Payer:	Southeast Health Services
Name of Provider: (ER, Hospital, or Other Facility)	Southeast Health Services
Name of Physician: (Treating or Requesting)	Bryan Weddle, DC

February 7, 2005

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

#### CLINICAL HISTORY

Available information suggests that this patient reports experiencing a low back injury when she slipped and fell at her place of employment on \_\_\_\_\_. She reports that the floor was slippery and she fell landing on her left hip. Her initial complaints consisted of low back pain, right hip pain and right knee pain. She was treated initially with chiropractic care by a Dr. Bryan Weddle, and was also seen by a Dr. Charles Willis for ESI injections to the lumbar spine. Lumbar MRI of 12/30/03 suggests no significant HNP or disc protrusion but does represent degenerative changes at L5/S1 segments. Advanced imaging of the right hip was found within normal limits. The patient appears to have undergone several weeks of conservative care with Dr. Weddle and Liberty Healthcare Center with treatments consisting of manipulation and multiple passive modalities. Working diagnosis with both Dr. Weddle and Dr. Willis appears to be that of lumbar disc degeneration with radiculopathy. A right knee MRI is performed 01/30/04 showing a fractional tear of the meniscus. The patient underwent orthopedic surgery with a Dr. Richard Marks on 04/19/04 for right knee meniscectomy, patellar chondroplasty and synovectomy.

#### REQUESTED SERVICE(S)

Determine medical necessity for office visits (99204), chiropractic manipulation (98941) manual therapy (97140-59), ultrasound therapy (97035), electric stimulation (97032), and mechanical traction (97012) for period in dispute 12/29/03 through 01/13/04.

#### DECISION

Deny chiropractic manipulation (98941).

Approve all other services.

### RATIONALE/BASIS FOR DECISION

Medical necessity for these reported treatments and services (12/29/03 through 01/13/04) **are generally supported as reasonable and customary for these conditions** by available documentation. However, the 98941 chiropractic manipulation service (3-4 areas) appears to exceed the level of care for conditions documented as compensable injury. In addition, this level of care is not supported in chiropractic treatment notes as causally related to these conditions.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. *J Manipulative Physiol Ther* 2002; 25(1):10-20.
3. Bigos S., et. al., AHCPR, 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. Morton JE. Manipulation in the treatment of acute low back pain. *J Man Manip Ther* 1999; 7(4):182-189.