

MDR Tracking Number: M5-05-1237-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 1-31-03.

The IRO reviewed medical necessity of work hardening program, office visit, ultrasound massage therapy, electrical stimulation unattended, hot/cold pack, therapeutic activities, and therapeutic exercises.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. 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.

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 February 20, 2003, 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 following table identifies the disputed services and Medical Review Division's rationale:

The respondent denied reimbursement based upon, "001 – The amount charged exceeds the maximum allowable fee for the Texas Workers' Compensation Medical Fee Guideline; and 070 – These services have been denied based on Forte's Physician Bill Review (PBR). Refer to the attached PBR Notice of Utilization Review Findings (NURF) for details. Any appeals related to these reductions need to be forwarded to Forte's Medical Bill."

The insurance carrier submitted a response to the request for medical dispute resolution on 3-11-03 indicating that, "As a result, there was no recommendation of additional reimbursement for this review, which is for the disputed amount of \$6,330.00. However, Carrier did previously pay \$453.60 towards the aforementioned disputed amount. Please refer to the attached bill review reports."

A review of the submitted EOBs from the insurance carrier indicate that all services after 2-22-02 were denied with EOB denial code "V."

III. RATIONALE

Forte gave preauthorization approval for 3 sessions of work hardening and FCE on report dated 5-13-02.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
2-19-02	97750FC (3)	\$300.00	\$100.00	001	\$100.00/hr X 3 = \$300.00	Medicine GR (I)(E)(2)	MAR reimbursement of \$300.00 is recommended. The difference between amount paid and MAR = \$200.00.
2-20-02 2-21-02 2-22-02	97545WHAP	\$128.00	\$64.00	F	\$64.00/hr	Medicine GR (II)(E)	MAR reimbursement of \$128.00 is recommended. The difference between amount paid and MAR = \$64.00 X 3 dates = \$192.00
TOTAL							The requestor is entitled to reimbursement of \$392.00

IV. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for CPT codes, 97750FC and 97545WH, in the amount of \$392.00. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby **ORDERS** the Respondent to remit **\$392.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 28th day of January 2005.

Elizabeth Pickle
 Medical Dispute Resolution Officer
 Medical Review Division

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-1237-01
Name of Patient:	
Name of URA/Payer:	Rehab 2112
Name of Provider: (ER, Hospital, or Other Facility)	Rehab 2112
Name of Physician: (Treating or Requesting)	Rhonda Dungan, DC

January 18, 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

Documents Reviewed Included the Following:

1. Correspondence, examination, and treatment notes from the provider
2. FCE reports
3. Psychological notes
4. Work hardening notes
5. Diagnostic imaging reports
6. Carrier EOBs
7. Carrier reviews

Patient under went diagnostic imaging, examinations and physical medicine treatments, including work hardening, after she tripped over the cord of a hair clipper and fell forward landing on her right side and striking her head on the floor while in the course of her employment as a hairdresser.

REQUESTED SERVICE(S)

97545-WH-CA Work Hardening, 97546-WH-CA Work Hardening Each Additional Hour, 99213-Office Visit Level III, 97035-Ultrasound, 97124-Massage Therapy, 97014-Electrical Stimulation Unattended, 97010-Hot/Cold Pack, 97530-Therapeutic Activities, 97110-Therapeutic Exercises from 02/25/02 through 04/30/02.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

No treatment records were available for review during the time period immediately preceding the treatment in question. Therefore, it is unknown what kinds of therapies and/or treatments had been attempted, what was beneficial and what was not, and were the disputed treatments different or more of the same. Without medical treatment records that answer those questions, there is less than sufficient documentation to support the medical necessity of the disputed treatment.

Current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises. There is also no strong evidence for the effectiveness of multidisciplinary rehabilitation as compared to usual care."¹ The literature further states "...that there appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities..."² And a systematic review of the literature for a multidisciplinary approach to chronic pain found only 2 controlled trials of approximately 100 patients with no difference found at 12-month and 24-month follow-up when multidisciplinary team approach was compared with traditional care.³ Based on those studies and absent any documentation that psychological treatment was even indicated, the work hardening program and the therapeutic exercises were medically unnecessary.

It is the position of the Texas Chiropractic Association⁴ that repeated use of acute care measures alone generally fosters chronicity, physician dependence and over-utilization and the repeated use of passive treatment/care tends to promote physician dependence and chronicity. Therefore, the medical necessity for the passive therapy that began on 03/25/02 (subsequent to 4 weeks of work hardening and 4 months post injury) was not supported. There were also no treatment notes furnished for the passive therapy or the 03/25/02 E/M service (99213).

¹ Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.

² Karjalainen K, Malmivaara A, van Tulder M, Roine R, Jauhiainen M, Hurri H, Koes B. Multidisciplinary biopsychosocial rehabilitation for neck and shoulder pain among working age adults. Cochrane Database Syst Rev. 2003;(2):CD002194.

³ Karjalainen K, et al. Multidisciplinary rehabilitation for fibromyalgia and musculoskeletal pain in working age adults. Cochrane Database of Systematic Reviews 2000;2.

⁴ Quality Assurance Guidelines, Texas Chiropractic Association.