

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 1-11-05.

The Division has reviewed the enclosed IRO decision and determined that **the Requestor did not prevail** on the majority of the medical necessity issues. 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.

The IRO reviewed unlisted special service-process-report, cervical pillow, unlisted modality, electrical stimulation, office visits, manual therapy technique, neuromuscular stimulator, analyze clinical data, therapeutic activities, nerve conduction, sensory-each nerve EMG, office visit-consultation, muscle testing-extremity, temp gradient studies, hot-cold pack, neuro process, therapeutic procedures-group, therapeutic exercises and supplies/materials that were denied by the carrier with a "V" or a "U" from 1-12-04 through 6-24-04.

The services listed above **were found** to be medically necessary from 1-12-04 through 2-25-04. The services listed above **were not found** to be medically necessary from 2-26-04 through 6-24-04. The respondent raised no other reasons for denying reimbursement for the above listed services. The amount due the requestor for the medical necessity issues is \$2,626.50.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute 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 2-10-05, the Medical Review Division submitted a Notice to the 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 99199 on 2-13-04 and 2-18-04 has been denied by the carrier as "855-002 – recommended allowance is in accordance with TWCC medical fee schedule guidelines." This is a DOP code and Per Rule 133.307(g)(3)(D), the requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has not provided evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. **Recommend no reimbursement.**

Regarding CPT code 95903 (4 units) on 3-2-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$361.16.**

CPT code 99199 on 2-17-04 and CPT code 99499 on 3-19-04 were denied by the carrier as "855-022 – Lack of sufficient documentation." Requestor did not submit relevant documentation to support service rendered per 133.307(g)(3)(B). **Recommend no reimbursement.**

CPT code 99080 on 6-10-04 was denied by the carrier as "N – not appropriately documented." Requestor did not submit relevant documentation to support service rendered per Rule 133.307(g)(3)(B). **Recommend no reimbursement.**

This Finding and Decision is hereby issued this 5<sup>th</sup> day of May, 2005.

Medical Dispute Resolution Officer  
Medical Review Division

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 totaling \$2,987.66 from 1-12-04 through 3-2-04 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or 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 hereby issued this 5<sup>th</sup> day of May, 2005.

Manager, Medical Necessity Team  
Medical Dispute Resolution  
Medical Review Division

Enclosure: IRO decision

**MCMC**

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity  
IRO Decision Notification Letter**

**MCMC IIc ▪ 88 Black Falcon Avenue, Suite 353 ▪ Boston, MA 02210 ▪ 800-227-1464 ▪ 617-375-7777  
(fax)**

**[mcman@mcman.com](mailto:mcman@mcman.com) ▪ [www.mcman.com](http://www.mcman.com)**

<b>Date:</b>	<b>4/20/05 5/3/05 AMENDED</b>
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<b>Injured Employee:</b>	
<b>MDR #:</b>	<b>M5-05-1353-01</b>
<b>TWCC #:</b>	
<b>MCMC Certification #:</b>	<b>5294</b>

**REQUESTED SERVICES:**

Review the items in dispute regarding CPT codes, 99199-unlisted special serv proc. or report (spanish translator; E0943-cervical pillow; 97039-unlisted modality; G0283-elec stimulation unattended; 99213-ov; 97140-manual therapy technique; E0745-neuromuscular stimulator elec shock unit; 99090-analy clinical data (no mod); 97530-ther. activities; 95900-nerve conduction; 95904-sensory each nerve; 95861-emg; 99243-ov cnslt new/est moderate severity; 95831-muscle testing-extremity; 93740-temp gradient studies; 97010-hot/cold pack; 99099-neuro proc; 97150-therapeutic procedures-group; 97110-therapeutic exer and 99214-ov. 99070 Supplies and Materials. Denied by carrier for medical necessity with "V" codes.

Dates of service in dispute: 01/12/2004 through 06/24/2004

**DECISION: PARTIAL**

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MCMC llc (MCMC) is an Independent Review Organization (IRO) that has been selected by The Texas Workers' Compensation Commission (TWCC) to render a recommendation regarding the medical necessity of the above disputed service.

Please be advised that a MCMC Physician Advisor has determined that your request for an M5 Retrospective Medical Dispute Resolution on 3/1/05, concerning the medical necessity of the above referenced requested service, hereby finds the following:

**The medical necessity of chiropractic care including the services listed above from 01/12/2004 through 02/25/2004 is established. The medical necessity for chiropractic care to include services listed above beyond 02/25/2004 is not established.**

**CLINICAL HISTORY:**

Records indicate that the above captioned individual, a 50-year-old-female, sustained injuries during the course of her normal employment, allegedly occurring on 01/08/2004. The history reveals that she slipped on some water and fell sustaining injuries to her neck and low back. The injured individual presented to the office of the Attending Provider (AP) on or about 01/12/2004. Chiropractic care ensued and a course of physical therapy was also administered. MRI exam of the cervical spine dated 03/26/2004 revealed multi-level spondylosis and a small protrusion at C3/C4 and larger protrusion at C4/C5. MRI of the lumbar spine was performed on 02/26/2004, revealing degenerative changes and bulging at L5/S1. Electrodiagnostic studies revealed L5 radiculopathy and a C6 radiculopathy. The injured individual has also undergone

medication management and injection therapy.

**RATIONALE:**

Given the mechanism of injury and presenting complaints, the injured individual was an appropriate candidate for chiropractic care beginning on or before 01/12/2004. The initial exam dated 01/09/2004 establishes in ranges of motion as well as orthopedic and neurologic assessments. Outcome assessment forms also established interference of activities of daily living. However, from 01/19/2004 through 02/25/2004 subjective pain levels varied wildly from each date of service and did not decrease. Furthermore, the reassessment dated 02/25/2004 did not establish any comparative data in regards to ranges of motion; ranges of motion were all listed as "mildly" restricted with pain. Given these factors, it is impossible to adequately ascertain if subjective and objective progress was being attained. Furthermore, a review of comparative outcome assessment forms from 01/12/2004 through 02/26/2004 does not clearly establish that the injured individual was significantly benefiting from the course of chiropractic care offered. The comparative findings of the Neck Pain Disability Index Questionnaire are either static, minimally improved or indicate deterioration of symptoms. Overall, the index changed from 64% to 58%. This does not clearly establish that the injured individual was significantly benefiting from the course of care offered beyond what might be reasonably expected from the natural history of the condition without the benefit of provider driven care. Furthermore, the Roland-Morris Acute low back pain questionnaire reveals a deterioration from 71%-75%. Therefore, the application of the chiropractic services listed above beyond 02/25/2004 is not established.

**RECORDS REVIEWED:**

- TWCC Notification of IRO Assignment dated 3/1/05
- TWCC MR-117 dated 2/10/05
- TWCC-60
- Concentra Integrated Services: Explanation of Review; Revised Explanation of Review
- MedConfirm: Peer Review dated 2/25/04
- Gilbert Mayorga, MD: Designated Doctor Examination (DDE) dated 6/17/04
- HealthSouth Evaluation Center: Evaluation Report dated 7/21/04; Functional Capacity Exam (FCE) dated 7/21/04, 6/23/04
- Martin Van Hal, MD: Office Notes dated 5/5/04 to 2/21/05
- Progressive Rehabilitation: Physical Therapy Evaluation dated 1/21/04; Physical Performance Evaluation dated 1/21/04; Examination and Electrodiagnostic Studies dated 2/17/04, 3/2/04; Health Management Program dated 2/6/04
- Southwest Diagnostic Imaging Reports: Cervical Myelogram dated 1/7/05 with Post-Myelogram Cervical Spine Computed Tomography; Lumbar Myelogram dated 8/9/04; Cervical Myelogram dated 1/7/05
- Medical Arts Surgery Center: Operative Report and Patient records dated 6/25/04
- Exploratory and Diagnostic Imaging: report of MRI of the C-spine dated 3/26/04; MRI of the lumbar spine dated 2/26/04
- Metro Quality Imaging: MRI of the lumbar spine dated 2/26/04
- John S. Parker, DO: Initial Consultation Note dated 1/9/04; Daily Progress and Procedural Notes for DOS 1/14/04 to 2/27/04, 3/1/04 to 1/7/05; Re-Assessment Consultation Note dated 2/25/04; Physical Performance Evaluation dated 2/24/04;

The reviewing provider is a Licensed Chiropractor and certifies that no known conflict of interest exists between the reviewing Chiropractor and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO. The reviewing physician is on TWCC's Approved Doctor List.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5)).

**In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of TWCC on this**

**\_\_3<sup>rd</sup>\_\_ day of \_\_MAY\_\_ 2005.**

**Signature of IRO Employee:** \_\_\_\_\_

**Printed Name of IRO Employee:** \_\_\_\_\_



**TEXAS  
WORKERS' COMPENSATION COMMISSION  
7551 Metro Center Drive, Suite #100, Austin, Texas 78744  
(512) 804-4800**

**MEMORANDUM**

**DATE:**        \_\_\_/\_\_\_/ 2005

**TO:**            **Austin Commission Representative**

**CARRIER:**   **American Casualty Company, Box 47**

**FROM:**        **Medical Review Division**

**RE:**            **NOTICE of Independent Review Organization and Medical Dispute Resolution  
DECISION & ORDER**

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**This memorandum shall serve as your notice to present yourself to the Mail Room Service Counter:**

(X)            An IRO and MDR Decision & Order.

The above referenced document has been issued in a medical dispute case review pertaining to the following claimant and insurance carrier:

**IDENTIFIER**

**MDR TRACKING #: M5-05-1353-01**  
**TWCC FILE #: 04375283**  
**CLAIMANT: Estella C. Alvarez**  
**DOI: 1-8-04**  
**SERVICE FROM: 1-12-04**  
**SERVICE TO: 6-24-04**

I, the undersigned Representative of the above referenced insurance carrier, do hereby acknowledge receipt of the IRO and MDR Decision & Order applicable to a medical dispute resolution request solicited by the requestor.

Receipt of this Decision & Order is hereby acknowledged this \_\_\_\_ day of \_\_\_\_\_ 2005.

Signature of Commission Representative: \_\_\_\_\_

Printed Name of Commission Representative: \_\_\_\_\_