

MDR Tracking #M5-05-1537-01

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. The dispute was received on 1-20-05.

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 office visits from 1-21-04 through 8-6-04 **were found** to be medically necessary. Chiropractic manipulation, neuromuscular re-education, supplies, mechanical traction, therapeutic exercise and massage **were not found** to be medically necessary. 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 \$520.50.

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 \$520.50 from 1-21-04 through 8-6-04 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 Findings and Decision and Order is hereby issued this 4th day of May, 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

Parker Healthcare Management Organization, Inc.
3719 North Belt Line Road, Irving, TX 75038
972.906.0603 972.255.9712 (fax)

April 22, 2005

ATTN: Program Administrator
Texas Workers Compensation Commission
Medical Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-1537-01
RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 3.28.05.
- Fax request for provider records made on 3.28.05.
- The case was assigned to a reviewer on 4.12.05.
- The reviewer rendered a determination on 4.19.05.
- The Notice of Determination was sent on 4.22.05.

The findings of the independent review are as follows:

Questions for Review

The therapies in dispute are office visits codes (99212 and 99213), chiropractic manipulation (98940 and 98942), neuromuscular re-education (97112), Misc. supplies (99070), therapeutic exercise (97110), massage (97124) and mechanical traction (97012). The therapy has been deemed as medically unnecessary. Disputed dates of service are 1.21.2004 through the date of 8.06.04.

Determination

Upon reviewing the medical records provided, it is determined that the office visits (99212 and 99213) from dates of service 1.21.04 through 8.06.04 **would have been medically necessary**. The other services provided such as chiropractic manipulation (98940, 98942), neuromuscular re-education (97112), supplies (99070), mechanical traction (97012), therapeutic exercise (97110) and massage (97124) **would not have been medically necessary**. These services are not documented as specifically making an impact in the patient's condition and do not appear to clearly create or provide a curative or symptom relieving affect.

Summary of Clinical History

According to the employer's first report of injury, the patient was injured on _____. The patient was a flight attendant with _____, International flights. She reported the injury occurred while pulling out the bar cart, when she felt pain in her lower back area, which radiated into her legs

Clinical Rationale

The office visits on the dates of 1.21.04, 2.11.04, 3.10.04, 4.02.04, 4.30.04, 5.21.04, 6.11.04, 6.25.04, 7.09.04 and 8.06.04 would have been reasonable and acceptable in order to monitor the patient's condition. The dates in question and the therapy services denied, do not show any documented link as to providing significant symptom relieving properties. It actually appears that during the time in question the patient actually had an increase in symptoms at various times. There is no clear documentation that those services in dispute had any connection to a favorable change in the patient's condition. The office visits are different as they are utilized to determine the need of a shift in care or used to monitor the patient. They were done at the appropriate intervals and time frames and do not appear to be extensive thus being necessary.

Clinical Criteria, Utilization Guidelines or other material referenced

Occupational Medicine Practice Guidelines, Second Edition.

The Medical Disability Advisor, Presley Reed MD

A Doctors Guide to Record Keeping, Utilization Management and Review, Gregg Fisher

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is a diplomat of the American Chiropractic Neurology Board, and serves as an Associate Professor with the Carrick Institute. The reviewer has added credentials in clinical nutrition, rehabilitation and electrodiagnostic medicine. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

In accordance with TWCC Rule 102.4 (h), a copy of this decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 22nd day of April, 2005.

If our organization can be of any further assistance, please feel free to contact me.

Sincerely,

Meredith Thomas
Administrator

CC: Suhail Al-Sahil, DC
Fax: 281.333.0442

Dean G. Pappas & Assoc for Insurance Co. of the State of PA
Attn: Renee Keeney
Fax: 512.347.0848

[Claimant]