

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 2-4-05.

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 the mechanical traction, therapeutic exercises, therapeutic activities, chiropractic manipulative treatment 1-2 regions and 3-4 regions, office visits, massage therapy, electrical stimulation-unattended for 2-6-04 through 11-23-04 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved.

On 2-24-05 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 98941 on 3-15-04 was denied by the carrier as "N –not documented." Review of the office notes submitted do not meet the documentation criteria set forth by the CPT Code descriptor. **Recommend no reimbursement.**

CPT code 97124 on 3-15-04 was denied by the carrier as "N –not documented." Review of the office notes submitted do not meet the documentation criteria set forth by the CPT Code descriptor. **Recommend no reimbursement.**

CPT code 97012 on 3-17-04 was denied by the carrier as "N –not documented." Review of the office notes submitted do not meet the documentation criteria set forth by the CPT Code descriptor. **Recommend no reimbursement.**

CPT code 98940 on 3-17-04 was denied by the carrier as "N –not documented." Review of the office notes submitted do not meet the documentation criteria set forth by the CPT Code descriptor. **Recommend no reimbursement.**

CPT code 99455-RP on 9-3-04 was denied by the carrier as "N –documentation doesn't justify the level of service and as "U – Unnecessary treatment." The requestor billed the above service in accordance with Rule 134.202 (e)(6)(D)(III). The Disability Exam is a required report and is not subject to an IRO review per Rule 130.2. The requestor submitted relevant information to support delivery of service, therefore, **reimbursement is recommended in the amount of \$371.00.**

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 \$371.00 on 9-3-04 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 Decision and Order is hereby issued this 15th day of April 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

April 7, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-05-1627-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 60 year-old female injured her left hip and neck on ___ when she was helping a student, turned and fell also injuring her left arm. She has been treated with therapy and medications.

Requested Service(s)

Mechanical traction, therapeutic exercises, therapeutic activities, chiropractic manipulative treatment – spinal, 1-2 regions, office visit, massage therapy, chiropractic manipulative treatment – spinal, 3-4 regions, electrical stimulation – unattended for dates of service 02/06/04 through 11/23/04

Decision

It is determined that there is no medical necessity for the mechanical traction, therapeutic exercises, therapeutic activities, chiropractic manipulative treatment – spinal, 1-2 regions, office visit, massage

therapy, chiropractic manipulative treatment – spinal, 3-4 regions, and electrical stimulation – unattended for dates of service 02/06/04 through 11/23/04 to treat this patient's medical condition.

Rationale/Basis for Decision

The Guidelines of *Chiropractic Quality Assurance and Practice Parameters*¹ Chapter 8 under “Failure to meet Treatment/Care objective” states, “After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered.” According to Medicare Guidelines, if a patient's expected restoration potential is insignificant in relation to the extent and duration of the physical medicine services required to achieve such potential, the services are not considered reasonable or necessary. In this case, medical record documentation indicates no improvement in the patient’s low back pain through the time period in question and obtained no relief from the treatment, promotion of recovery was not accomplished and there was no enhancement of the employee’s ability to return to employment. The disputed services failed to fulfill the statutory requirement² for medical necessity. Therefore, the mechanical traction, therapeutic exercises, therapeutic activities, chiropractic manipulative treatment – spinal, 1-2 regions, office visit, massage therapy, chiropractic manipulative treatment – spinal, 3-4 regions, and electrical stimulation – unattended for dates of service 02/06/04 through 11/23/04 were not medically necessary to treat this patient's medical condition.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." in a cursive style.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

¹ Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractor Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.

² Texas labor Code 408.021

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-1627-01

Information Submitted by Requestor:

- Office Notes
- Daily Notes
- Maximum Impairment Rating
- Diagnostic Tests

Information Submitted by Respondent: