

MDR Tracking Number: M5-05-2129-01

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 03-29-05.

CPT code 99358-52 date of service 10-06-04 is invalid for Medicare with the modifier 52 and will not be part of the review. CPT code 99080-73 date of service 09-13-04 was paid via check # 10411656 per the EOB submitted by the Respondent and is therefore no longer in dispute.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. The IRO agrees with the previous determination that the manual therapy technique, therapeutic exercises, electrical stimulation – unattended, mechanical traction, whirlpool, x-ray of the lower spine, x-ray of shoulder, somatosensory testing, office visits except from 07-06-04 through 08-06-04 and chiropractic manipulative treatment from 07-06-04 through 08-06-04 **were not** medically necessary. The IRO determined that the office visits from 07-06-04 through 08-06-04 and the chiropractic manipulative treatment from 07-06-04 through 08-06-04 **were** medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee. The amount of reimbursement due from the carrier equals **\$27.86**.

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 the only issue** to be resolved. The manual therapy technique, therapeutic exercises, electrical stimulation – unattended, mechanical traction, whirlpool, x-ray of the lower spine, x-ray of shoulder, somatosensory testing, office visits except from 07-06-04 through 08-06-04 and chiropractic manipulative treatment from 07-06-04 through 08-06-04 **were not** medically necessary. The office visits from 07-06-04 through 08-06-04 and the chiropractic manipulative treatment from 07-06-04 through 08-06-04 **were** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 for date of service 07-13-04 totaling \$27.86 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 of receipt of this order.

This Findings and Decision and Order are hereby issued this 23rd day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-2129-01
Name of Patient:	
Name of URA/Payer:	Marsha R. Miller, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician:	Marsha R. Miller, DC
(Treating or Requesting)	

May 20, 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 injuries to his shoulder and lower back that resulted from a fall out of the back of a truck during his regular course of employment on _____. He was seen initially at the Terrell ER. He is referred for orthopedic evaluation by Abraham Abdo, MD, and is found with cervical strain, right shoulder strain and low back pain with lumbar radiculopathy. X-rays and EMG are reported to be unremarkable. MRI studies appear to be ordered, patient is given medications and referred for physical therapy with Terrell Physical Therapy and Rehab Center. Some conservative care and physical therapy appears to have been initiated by Adrian Sobrevilla, LPT. The patient appears to begin a plan of treatment consisting of electric stimulation, ultrasound, mobilization and therapeutic exercise. The patient receives home exercise instruction and is apparently seen for conservative care until re-evaluation with Dr. Abdo on 04/26/04. The patient appears to see a Richard Keene, MD for another medical opinion on 04/29/04. MRI of the shoulder and lumbar spine is again requested as well as orthopedic consultation. Additional medications and a shoulder sling appear to be provided. No

additional information is provided until patient presents to a chiropractor, Marsha Miller, DC, on 07/06/04. Dr. Miller appears to repeat x-rays and re-orders physical therapy modalities at a frequency of 3x per week for 4 weeks. No significant progressive improvement of conditions is reported in chiropractic reporting with this continued level of physical therapy. The patient is eventually referred to a Dr. Cunningham for orthopedic management of ongoing shoulder conditions. The patient is also referred to a Dr. Henderson, Dr. Harvard and a Dr. Hashmi for medical/surgical management of persisting lower back complaints. Designated doctor evaluation is made on 08/31/04 by a Dr. Stetzner indicating that the patient has not yet achieved MMI, and should receive additional medical/surgical treatment for his injuries including ESIs and appropriate surgical intervention.

REQUESTED SERVICE(S)

Determine medical necessity for office visits (99211/99213), unattended electric stimulation (GO283), therapeutic exercise (97110), whirlpool (97022), chiropractic manipulation (98940), mechanical traction (97012), x-ray exam of the lumbar spine (72110), x-ray exam of the shoulder (73030), manual therapy (97140) and somatosensory testing (95927/95926) for dates in dispute 07/13/04 through 10/19/04.

DECISION

Approved. 99211/99213 – Reasonable medical necessity demonstrated from 07/06/04 to 08/06/04 only.

Approved. 98940 – Reasonable medical necessity demonstrated from 07/06/04 to 08/06/04 only.

Denied. 97140 – Duplicative with no specific documentation of medical necessity.

Denied. 97110 – Duplicative with no specific documentation of medical necessity.

Denied. GO283 - Duplicative with no specific documentation of medical necessity.

Denied. 97012/97022 – Passive applications with no medical necessity or curative potential at this phase of care.

Denied. 72110/73030 – Duplicate imaging not medically necessary.

Denied. 95927/95926 – Not medically necessary as provided.

RATIONALE/BASIS FOR DECISION

There appears to be some reasonable medical necessity for a chiropractic care trial regarding these conditions for a limited period of time or at least until appropriate medical/surgical management can be obtained. Chiropractic office visits (99211/99213) appear reasonably appropriate for the initial trial of four weeks initially requested in order to determine if this treatment provides any significant benefit and/or to triage the patient into appropriate specialty management. Chiropractic daily treatment reporting is very poor and does not provide any specific clinical rationale for the ongoing chiropractic care plan.

It would appear that either 98940 chiropractic manipulation or 97140 manual therapy would be reasonable treatment/management during this initially requested four week period.

Medical necessity for these ongoing modalities (97110, 97022, 97012, G0283) **are not supported** by available documentation and appear to be a duplication of earlier physical therapy provided with no clinical benefit. Ongoing therapeutic modalities of this nature suggest little potential for further restoration of function or resolution of symptoms, and suggest no curative potential for conditions objectively diagnosed. In addition, 72110/73030 imaging appears to be a duplication of x-rays already performed and available for review. Somatosensory testing (95927/95926) appears to have little clinical utility or demonstrated medical necessity given other objective tests performed.

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.

6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

7. American Association of Electrodiagnostic Medicine, "Dermatosensory Evoked Potentials; Somatosensory Testing", Journal of Neurology, October 1997.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.