

MDR Tracking Number: M5-05-2266-01

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 (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 4-18-05.

The IRO reviewed durable medial equipment, office visits, mechanical traction, chiropractic manipulative treatment-spinal, diathermy, massage therapy, TENS DME, therapeutic exercises, group therapeutic procedures, muscle testing, ROM measurement-EA medical records, Biofreeze DME from 4-26-04 through 7-13-04.

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 durable medial equipment, office visits, mechanical traction, chiropractic manipulative treatment-spinal, diathermy, massage therapy, TENS DME therapeutic exercises, group therapeutic procedures, muscle testing, ROM measurement-EA medical records, Biofreeze DME from 4-26-04 through 5-24-04 **were found** to be medically necessary. The durable medial equipment, office visits, mechanical traction, chiropractic manipulative treatment-spinal, diathermy, massage therapy, TENS DME therapeutic exercises, group therapeutic procedures, muscle testing, ROM measurement-EA medical records, Biofreeze DME from 5-25-04 through 7-13-04 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. CPT code 97139-EU is not valid for Medicare and no reimbursement is recommended for these services. Regarding CPT code 98943: The Commission has not established a maximum allowable reimbursement. 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 sample EOBs or other evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. The amount due the requestor for the medical necessity issues is \$3,900.89.

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. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 5-16-05 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.

Regarding CPT code 99080-73 on 4-30-04 and 5-14-04 was denied with a "U" for unnecessary medical treatment; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. A referral will be made to Compliance and Practices for this violation. The Medical Review Division has jurisdiction in this matter. **Recommend reimbursement of \$30.00 (\$15.00 X 2 DOS).**

This Finding and Decision is hereby issued this 8th day of July 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 \$3,930.89 from 4-26-04 through 5-24-04 in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) 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 8th day of July 2005.

Manager, Medical Necessity Team
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

June 13, 2005

June 9, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

**REVISED REPORT
Corrected Items in Dispute
(Remove electrical stimulation)**

Re: Medical Dispute Resolution
MDR #: M5-05-2266-01
TWCC#:
Injured Employee: ____
DOI: ____
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
General Counsel

GP:thh

REVIEWER'S REPORT
M5-05-2266-01

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Correspondence

Office visits 04/26/04 – 05/11/04

Daily notes 04/26/04 – 07/13/04

Therapeutic procedure notes 05/03/04 – 07/07/04

Range of motion testing 05/11/04

Information provided by Pain Management Specialist:

Office note 04/28/04

Clinical History:

The claimant underwent examinations and physical medicine treatments after sustaining injury on ____.

Disputed Services:

Durable medical equipment, office visits, mechanical traction, chiropractic manipulative treatment-spinal, diathermy, massage therapy, TNS DME #5 or #6, therapeutic exercise, group therapeutic procedures, muscle testing, ROM measurement-EA, medical records, Biofreeze DME #28 during the period of 04/26/04 through 07/13/04.

Decision:

The reviewer partially agrees with the determination of the insurance carrier as follows:

Medically Necessary during the period of 04/26/04 through 05/24/04:

DME #33, #28, #22 (99070)

Mechanical traction (97012)

Chiropractic manipulative treatment (98940 & 98943)

Diathermy (97024)

Massage therapy (97124)

TENS DME #5 or #6 (99070)

Therapeutic exercises (97110)

Group therapeutic procedures (97150)

Biofreeze DME #28 (A9150)

Office visit on 05/11/04 (99213)

Not Medically Necessary:

All treatment and services in dispute rendered after 05/25/04.

Rationale:

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters*¹ Chapter 8 under "Failure to Meet Treatment/Care Objectives" 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." Therefore, the medical necessity for a portion of the treatment from 04/26/04 through 05/24/04 is supported.

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

Since there was no “significant documented improvement” during this 4-week time period, all treatment after 05/25/04 is denied. In fact, the medical records fail to substantiate that the services fulfilled the statutory requirements² since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee’s ability to return to employment. Specifically, the claimant’s pain ratings remained unchanged from the initiation of treatment on 04/27/04 (3/10), to the end of the 4-week period on 05/24/04 (3/10) to the termination of the disputed treatment on 07/13/04 (3/10). Moreover, there was no qualitative or quantitative documentation of improvement since no follow up range of motion examinations were performed after 05/11//04.

And finally, according to CPT³ there is no support for the medical necessity for the 99211-25 office visit; 99212-25 office visit; 99213-25 office visit; 97750-MT muscle testing; 95851 ROM measurement; 99211 office visit; and 99212 office visit. That is especially true in this case since those services were delivered during what was an established treatment plan.

² Texas Labor Code 408.021

³ *CPT 2004: Physician’s Current Procedural Terminology, Fourth Edition, Revised.* (American Medical Association, Chicago, IL 1999),