



Texas Department of Insurance, Division of Workers' Compensation  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### Retrospective Medical Necessity and Fee Dispute

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  James Tanner, D. C. 5350 Staples Ste. 210 Corpus Christi, Texas 78411	MDR Tracking No.: M5-06-1394-01
	Previous No.: M4-05-8080-01
	Claim No.:
Respondent's Name and Address:  Texas Mutual Insurance Company, Box 54	Injured Employee's Name:
	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Position Summary states that the Requestor believes that a clerical error was made regarding CPT code 97110 as 4 units were billed on each date of service. However, the EOB indicates that there was only one unit billed.

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position statement submitted by Texas Mutual does not address the disputed issues.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-20-04 – 11-23-04	CPT code 97110 (\$34.46 X 18 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$620.28
8-26-04 – 11-23-04	CPT code 98940, 97140-59, 97012, G0283	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Total		\$620.28

#### PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the Requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on the majority of the disputed medical necessity issues. The amount due the Requestor for the items denied for medical necessity is \$620.28.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

Texas Labor Code 413.011 and 413.031  
28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202.

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the Requestor is not entitled to a refund of the paid IRO fee. The Division has determined that the Requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$620.28. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision and Order by:

Medical Dispute Officer

01-05-07

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Date of Order

**PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW**

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

June 7, 2006

TX DEPT OF INS DIV OF WC  
AUSTIN, TX 78744-1609

CLAIMANT: \_\_\_\_

EMPLOYEE: \_\_\_\_

POLICY: M5-06-1394-01/

CLIENT TRACKING NUMBER: M5-06-1394-01

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**AMENDED REVIEW:**

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIoA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

**Records Received:**

FROM THE STATE OF TEXAS:

Notification of IRO assignment 5/11/06 – 1 page  
Texas Department of Insurance Division of Workers Compensation form 5/11/06 – 1 page  
Table of disputed services – 2 pages  
Medical dispute resolution request/response form – 1 page  
Provider form – 1 page  
Medical dispute resolution request/response form – 1 page  
Letter from Texas Mutual 4/17/06 – 1 page  
Explanation of Benefits from Texas Mutual 9/20/04 – 9/24/04 - 2 pages  
Explanation of Benefits from Texas Mutual 9/15/04 – 9/17/04 – 1 page  
Explanation of Benefits from Texas Mutual 9/13/04 – 9/15/04 – 1page  
Explanation of Benefits from Texas Mutual 9/7/04 – 9/10/04 – 2 pages  
Explanation of Benefits from Texas Mutual 8/26/04 - 8/27/04 – 1 page

FROM THE REQUESTOR/James Tanner DC:

Request for reconsideration 3/16/05 – 3 pages  
Initial narrative report 7/28/04 – 6 pages  
Daily patient notes 7/28/04 – 8/13/04 – 1 page  
Daily patient notes 8/16/04 – 8/27/04 – 1 page  
MRI lumbar spine report 8/30/04 – 1 page  
Patient progress record 9/2/04 – 2 pages  
Patient progress record 9/10/04 – 2 pages  
Patient progress record 9/17/04 – 2 pages  
Patient progress record 9/24/04 – 2 pages  
Progress notes 10/5/04 – 1 page  
Letter from Alejandro Echeverry, MD 10/14/04 – 1 page  
History and Physical 10/18/04 – 2 pages  
Operative report 10/26/04 – 1 page  
Discharge summary 10/26/04 – 1 page  
Operative report 11/16/04 – 1 page  
Discharge summary 11/16/04 – 1 page  
Operative report 12/14/04 – 1 page

Discharge summary 12/14/04 – 1 page

Texas Workers Compensation Commission form 9/27/04 – 1 page

Report of medical evaluation 10/14/04 – 1 page

FROM THE RESPONDENT/Texas Mutual Insurance Co:

Letter from Texas Mutual 5/31/06 – 2 pages

Patient progress record 10/6/04 – 2 pages

Patient progress record 10/14/04 – 2 pages

History and Physical 10/18/04 – 2 pages

Functional capacity evaluation 11/15/04 – 6 pages

Letter from Dr. James D. Tanner, MD 12/8/04 – 1 page

**Summary of Treatment/Case History:**

The patient is an adult female who slipped and fell on soapy water on \_\_\_ and she injured her back and her arms. She presented to the chiropractor on 7/28/04 with complaints of lumbar pain, cervical pain, right wrist pain, and left wrist pain. The examination revealed reduced cervical and lumbar ranges of motion in all planes and locally positive cervical and lumbar orthopedic tests. The chiropractor indicated that the patient had positive straight leg raising signs at 25 degrees on the right and 20 degrees on the left.

Lower extremity reflexes were reduced on the left side and hypoesthesia was noted on the left side in the L4 to S1 distribution. Weakness was reported globally in left lower extremity muscles and the patient was diagnosed with cervical sprain/strain, bilateral wrist sprain, muscle spasms, lumbar radiculitis, and lumbar intervertebral disc disorder. The patient began a course of treatment that included joint mobilization, manipulation, electrical stimulation, hot packs, ultrasound, massage, intersegmental traction, and exercises. The patient was treated on the following dates:

7/28/04, 7/29/04, 7/30/04, 8/02/04, 8/04/04, 8/06/04, 8/09/04, 8/11/04, 8/13/04, 8/16/04, 8/18/04, 8/20/04, 8/23/04, 8/26/04, 8/27/04, 9/02/04, 9/07/04, 9/08/04, 9/10/04, 9/13/04, 9/15/04, 9/17/04, 9/20/04, 9/22/04, 9/24/04, 10/04/04, 10/05/04, 10/06/04, 10/11/04, 10/13/04, 10/14/04.

The patient underwent a lumbar MRI study on 8/30/04 that revealed a 4 mm broad based left subarticular and foraminal disc herniation flattening the thecal sac with severe narrowing of the left and mild narrowing of the right intervertebral foramen at L5-S1.

The patient underwent a required medical examination with a designated doctor on 10/14/04 and the designated doctor determined the patient was not at maximum medical improvement and that she was having radicular pain in her lower extremity on the left side. He recommended a series of epidural steroid injections, as well as EMG/NCV evaluation of the lower extremity.

The patient underwent an evaluation with Thomas Edwards MD on 10/18/04 and she was scheduled for a series of three epidural steroid injections. She underwent lumbar ESI's on 10/26/04, 11/16/04, and 12/14/04.

The patient underwent a functional capacity evaluation on 11/15/04 and the FCE revealed she was functioning at the LIGHT physical demand level and her job required her to function at the MEDIUM-HEAVY physical demand level.

**Questions for Review:**

1. Services in dispute: man, ther. techn- #97140 DOS 8/26/04, 9/7/04, 9/8/04, 9/10/04, 9/13/04, 9/15/04, 9/17/04, 9/20/04, 9/22/04, 9/24/04, ther. exercises-#97110 DOS 9/20/04, 9/22/04, 9/24/04, 10/4/04, 10/14/04, 11/22/04, 11/23/04. Mech. traction-#97012 DOS 9/20/04, 9/22/04, 9/24/04. Ele stim unattended- #G0283 DOS 9/20/04, 9/22/04, 9/24/04. Chiro man. treatment- spinal-#98940 DOS 9/20/04, 9/22/04, 9/24/04 denied for medical necessity.

**Explanation of Findings:**

Manual therapy techniques (#97140) were not medically necessary for dates of service 8/26/04, 9/7/04, 9/8/04, 9/10/04, 9/13/04, 9/15/04, 9/17/04, 9/20/04, 9/22/04 and 9/24/04. The medical records reviewed provided no explanation as to the regions of the body treated with manual therapy (joint mobilization) treatments, and, as the patient was also receiving chiropractic care, the addition of manual therapy treatments represented duplication of services.

The use of therapeutic exercises (#97110) for dates of service 9/20/04, 9/22/04, 9/24/04, 10/4/04, 11/22/04 and 11/23/04 were medically necessary.

Haldeman et al indicate that it is beneficial to proceed to the rehabilitation phase of care as rapidly as possible to minimize dependence on passive forms of treatment/care and reaching the rehabilitation phase as rapidly as possible and minimizing dependence on passive treatment usually leads to the optimum result (Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993)

The Philadelphia Panel found that therapeutic exercises were found to be beneficial for chronic, subacute, and post-surgery low back pain. Continuation of normal activities was the only intervention with beneficial effects for acute low back pain. (Philadelphia Panel Evidence-Based

Guidelines on Selected Rehabilitation Interventions for Low Back Pain. Phys Ther. 2001;81:1641-1674).

The use of mechanical traction (#97012) for dates of service 9/20/04, 9/22/04, and 9/24/04 were not medically necessary. The Royal College of General Practitioners indicates that there are now 24 randomized controlled trials of various forms of traction in neck and back pain but they are generally of poor quality. Traction does not appear to be effective for low back pain or radiculopathy. (Royal College of General Practitioners, Clinical Guidelines for the management of Acute Low Back Pain, Review Date: December 2001)

The European Guidelines for the Management of Acute Nonspecific Low Back Pain in Primary Care indicate that traction is not effective for the treatment of low back pain and the guideline recommends against the use of traction in the management of acute back pain (Van Tulder, M, et al, "European Guidelines for the Management of Acute Nonspecific Low Back Pain in Primary Care", COST B13 Working Group for the Management of Acute Low Back Pain in Primary Care, 2004).

The use of unattended electrical stimulation (#G0283) for dates of service 9/20/04, 9/22/04, and 9/24/04 were not medically necessary. The Philadelphia Panel found that therapeutic exercises were found to be beneficial for chronic, subacute, and post-surgery low back pain. Continuation of normal activities was the only intervention with beneficial effects for acute low back pain. For several interventions and indications (eg, thermotherapy, therapeutic ultrasound, massage, electrical stimulation), there was a lack of evidence regarding efficacy. (Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Low Back Pain. Phys Ther. 2001;81:1641-1674).

The ACOEM Guidelines indicate that physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, TENS units, percutaneous electrical nerve stimulation units and biofeedback have no proven efficacy in the treatment of lower back pain symptoms (ACOEM Guidelines – Low Back Pain, 2003)

The Philadelphia Panel indicated that for neck pain, therapeutic exercises were the only intervention with clinically important benefit. There was good agreement with this recommendation from practitioners (93%). For several interventions and indications (eg, thermotherapy, therapeutic ultrasound, massage, electrical stimulation), there was a lack of evidence regarding efficacy. (Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Neck Pain. Phys Ther. 2001;81:1701-1717.)

The use of chiropractic manipulation (#98940) for dates of service 9/20/04, 9/22/04, and 9/24/04 were not medically necessary.

The patient had already received 22 visits with the chiropractor prior to 9/20/04 and there was no evidence in the records reviewed of continued benefits associated with manipulation in the records reviewed.

The overall duration of treatment with manipulation was excessive and chiropractic literature does not support the protracted use of manipulation in cases of prolonged duration. Chiropractic literature clearly demonstrates that the response to manipulation diminishes as the length of the condition increases. McDonald and Bell, in an open controlled pilot trial on nonspecific low back pain patients to assess the effects of spinal manipulation (McDonald, R.S., and Bell, C., "An open controlled assessment of osteopathic manipulation in nonspecific low back pain", Spine, 15:364-370, 1990), found that after 4-6 weeks there was no appreciable improvement in the disability index (a measure of activities of daily living interference).

Patients with acute complicated non-surgical lower back disorders generally only require 12 visits over the course of five weeks and chronic complicated non-surgical lower back disorders generally require no more than 14 visits over 8 weeks (Expert Clinical Benchmarks: "Low Back", King of Prussia, PA, MedRisk, Inc. 2003)

Triano studied the differences in treatment history with manipulation for acute, subacute, and recurrent spine pain and found that all but 25 (10.37%) of the original 241 patients in the study had their conditions resolve in six weeks or less. (Triano, J.J., et al, "Differences in treatment history with manipulation for acute, subacute, chronic, and recurrent spine pain", JMPT, 15:24-30, 1992.)

Haldeman reported that manipulation appears to have its greatest effect immediately following treatment and during the initial two to six weeks of ongoing treatment. Haldeman noted that the effectiveness of manipulation for the management of back pain seems to be minimal at 3 months to 12 months (Haldeman, S. "Spinal manipulative therapy: A status report", Clinical Orthopedics and Related Research, 179:62-70, 1983).

Bronfort noted that, based on the most recent and comprehensive systematic reviews, there is moderate evidence of short-term efficacy for spinal manipulation in the treatment of both acute and chronic low back pain. There is insufficient data available to draw conclusions regarding the efficacy for lumbar radiculopathy. The evidence is also not conclusive for the long-term efficacy of spinal manipulation for any type of low back pain. (Bronfort G. "Spinal manipulation: current state of research and its indications." Neurol Clin 1999 Feb;17(1):91-111)

#### **Conclusion/Partial Decision to Certify:**

1. Services in dispute: man, ther. techn- #97140 DOS 8/26/04, 9/7/04, 9/8/04, 9/10/04, 9/13/04, 9/15/04, 9/17/04, 9/20/04, 9/22/04, 9/24/04, ther. exercises-#97110 DOS 9/20/04, 9/22/04, 9/24/04, 10/4/04, 10/14/04, 11/22/04, 11/23/04. Mech. traction-#97012 DOS 9/20/04, 9/22/04, 9/24/04. Ele stim unattended- #G0283 DOS 9/20/04, 9/22/04, 9/24/04. Chiro man. treatment- spinal-#98940 DOS 9/20/04, 9/22/04, 9/24/04 denied for medical necessity.

The use of therapeutic exercises (#97110) for dates of service 9/20/04, 9/22/04, 9/24/04, 10/4/04, 11/22/04 and 11/23/04 were medically necessary.

**Conclusion/Decision to Not Certify:**

Manual therapy techniques (#97140) were not medically necessary for dates of service 8/26/04, 9/7/04, 9/8/04, 9/10/04, 9/13/04, 9/15/04, 9/17/04, 9/20/04, 9/22/04 and 9/24/04. The use of mechanical traction (#97012) for dates of service 9/20/04, 9/22/04, and 9/24/04 were not medically necessary.

The use of unattended electrical stimulation (#G0283) for dates of service 9/20/04, 9/22/04, and 9/24/04 were not medically necessary.

The use of chiropractic manipulation (#98940) for dates of service 9/20/04, 9/22/04, and 9/24/04 were not medically necessary.

**Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:**

Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993

**References Used in Support of Decision:**

- Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Low Back Pain. Phys Ther. 2001;81:1641-1674).
- Royal College of General Practitioners, Clinical Guidelines for the management of Acute Low Back Pain, Review Date: December 2001
- Van Tulder, M, et al, "European Guidelines for the Management of Acute Nonspecific Low Back Pain in Primary Care", COST B13 Working Group for the Management of Acute Low Back Pain in Primary Care, 2004
- Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Low Back Pain. Phys Ther. 2001;81:1641-1674
- ACOEM Guidelines – Low Back Pain, 2003
- Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Neck Pain. Phys Ther. 2001;81:1701-1717
- McDonald, R.S., and Bell, C., "An open controlled assessment of osteopathic manipulation in nonspecific low back pain", Spine, 15:364-370, 1990
- Expert Clinical Benchmarks: "Low Back", King of Prussia, PA, MedRisk, Inc. 2003)
- Triano, J.J., et al, "Differences in treatment history with manipulation for acute, subacute, chronic, and recurrent spine pain", JMPT, 15:24-30, 1992
- Haldeman, S. "Spinal manipulative therapy: A status report", Clinical Orthopedics and Related Research, 179:62-70, 1983

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This review was provided by a Doctor of Chiropractic who is also a member of the American Chiropractic Academy of Neurology. This reviewer also holds a certification in Acupuncture. This reviewer has fulfilled both academic and clinical appointments and currently serves as an assistant professor at a state college, is in private practice and is a director of chiropractic services. This reviewer has previously served as a director, dean, instructor, assistant professor, and teaching assistant at a state college and was responsible for course studies consisting of pediatric and geriatric diagnosis, palpation, adjusting, physical therapy, case management, and chiropractic principles. This reviewer is responsible for multiple postgraduate seminars on various topics relating to chiropractics and has authored numerous publications. This reviewer has participated in numerous related professional activities including work groups, committees, consulting, national healthcare advisory committees, seminars, National Chiropractic Coalition, media appearances, and industrial consulting. This reviewer has been in practice since 1986.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the DWC.

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The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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Case Analyst: Cherstin B ext 597

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