THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-0843.M5

MDR Tracking Number: M5-03-0935-01

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. This dispute was received on 12-2-02.

The IRO reviewed chiropractic treatment, DME, DME supplies rendered from 12-3-01 to 6-7-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-3-01 12-4-01 12-6-01 12-7-01 12-10-01 12-11-01 12-12-01 12-13-01 12-14-01 12-17-01 12-19-01 12-20-01 12-26-01 12-27-01 12-28-01 1-2-02 1-3-02 1-4-02 1-7-02 1-9-02 1-11-02 1-14-02	97110 (6 units)	$210.00	$0.00	U	$35.00 / 15 min X 6 units = $210.00	Section 408.021(a)	IRO concluded these services were medically necessary, reimbursement is recommended of 27 dates X $210.00 = $5670.00.

1-16-02 1-17-02 1-21-02 1-23-02 1-25-02							
1-9-02 1-28-02	97112	$35.00	$0.00	U	$35.00 / 15 min	Section 408.021(a)	IRO concluded these services were medically necessary, reimbursement is recommended of 2 dates X $35.00 = $70.00.
1-25-02	99215	$103.00	$0.00	U	$103.00	Section 408.021(a)	IRO concluded these services were medically necessary, reimbursement is recommended of $103.00.
1-28-02 1-29-02 2-1-02 2-4-02 2-6-02 2-8-02 2-11-02 2-13-02 2-15-02 2-18-02 2-20-02 2-22-02 2-27-02 3-1-02 3-4-02 3-5-02 3-7-02 3-11-02 3-13-02 3-14-02 3-15-02 3-18-02 3-21-02	99213	$48.00	$0.00	U	$48.00	Section 408.021(a)	IRO concluded these services were medically necessary, reimbursement is recommended of 23 dates X $48.00 = $1104.00.
1-28-02	97530	$210.00	$0.00	U	$35.00 / 15 min	Section 408.021(a)	IRO concluded these services were medically necessary, reimbursement is recommended of $210.00.
TOTAL		$7157.00					The requestor is entitled to reimbursement of **$7157.00.**

The IRO concluded that the following services were medically necessary: 97110, 97112 and 97530 codes rendered from 12/3/01 through 1/28/02; 99215 on 1-25-02; and office visits, code 99213, once a week from 1/29/02 through 3/22/02. All other services were not medically necessary.

On this basis, the total amount recommended for reimbursement ($7157.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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

On June 16, 2003, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

Neither party submitted EOBs to support why EOB denial code "D" was used; therefore, these services will be reviewed in accordance with *Medical Fee Guideline.*

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
2-27-02	E0745	$165.00	$0.00	A	DOP	Rule 134.600(h)(11)	Neuromuscular stimulator unit – Preauthorization approval report was not submitted; no reimbursement is recommended.
3-20-02	99213	$48.00	$0.00	D	DOP	Rule 133.307(g)(3)	The requestor did not submit medical records to support services billed per MFG.
3-27-02	97250	$43.00	$0.00	D	DOP		
4-30-02 5-7-02 5-13-02	99070	$15.00	$0.00	D	DOP		
4-24-02	E0745	$165.00	$0.00	D	DOP		
	99070	$15.00	$0.00	D	DOP		
	E1399	$32.00	$0.00	D	DOP		

TOTAL	$907.00		The requestor is not entitled to reimbursement .

This Decision is hereby issued this 10th day of September 2003.

Elizabeth Pickle
Medical Dispute Resolution
Medical Review Division

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees 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 Decision is applicable for dates of service 12-3-01 through 6-7-02 in this dispute.

This Order is hereby issued this 10th day of September 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 2, 2003

Requester/ Respondent Address : Rosalinda Lopez
TWCC
4000 South IH-35, MS-48
Austin, Texas 78704-7491

RE: MDR Tracking #: M5-03-0935-01
IRO Certificate #: 5242

___ 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 ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed 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 Chiropractic physician reviewer. The Chiropractic physician reviewer 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 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

It appears the claimant was employed as a "rod buster" on ___ when he fell from a height that was reported to be 21-22 feet when the sling which was supposed to hold him near the ceiling broke. The claimant reportedly lifts, assembles and manipulates rebar for commercial ceilings and floors. His harness or sling that held him up near the ceiling reportedly broke and he hit the ground. The claimant suffered multiple blunt trauma injuries. The claimant reportedly underwent multiple MRI evaluations and electrodiagnostic tests at a local hospital. The claimant ended up having lumbar surgery at the L5/S1 level on 5/16/02. The claimant underwent electrodiagnostic work up with a physician on 2/14/02. The electrodiagnostic studies were of the bilateral upper and lower extremities. These revealed an L4 left sided radiculopathy that was noted to be chronic and severe as well as an S1 radiculopathy on the left which was chronic and moderately severe. There was also noted to be a C5 radiculopathy on the left that was also chronic and moderately severe. The physician's exam of 2/14/02 revealed the claimant to be antalgic and using a cane for ambulation. The claimant had a decreased Achilles reflex on the left. The claimant came under chiropractic care on or about 10/31/01; however, it appears that formal active chiropractic related physical therapy was not begun until 12/3/01 and this was probably due to the claimant's severe amount of pain. I do not know if the claimant received passive therapy or any kind of physical therapy prior to 12/3/01 which is prior to the disputed dates of services anyway. The chiropractic notes for dates of services that are in dispute are reviewed. There are multiple follow up examinations and re-evaluations that occur about once per month from 12/3/01 onward. The overall objective findings seem to show improvement over time.

Requested Service(s)

Chiropractic related services to include physical therapy, durable medical equipment (DME), DME supplies, manipulations and office visits from 12/3/01 through 6/7/02.

Decision

I disagree with the insurance carrier and find that the active care procedures administered from 12/3/01 through 1/28/02 were reasonable and medically necessary and generally supported by the documentation and injury. The 97110, 97112 and 97530 codes which were billed and rendered from 12/3/01 through 1/28/02 were in my opinion reasonable, medically necessary and supported by the documentation. The 99215 code that was used on 1/25/02 was in my opinion reasonable and medically necessary as this represented a well documented comprehensive office visit by the chiropractor. I agree with the insurance carrier that use of the 99070 code, which is a nonspecific supply code, probably in this case used for distribution of electric stimulation pads or the 4 ounce analgesic cream that was used was not medically reasonable or medically necessary.

I agree with the insurance carrier that all chiropractic related services rendered and billed beyond 1/28/02 were not reasonable or medically necessary with the exception of the chiropractic office visit code of 99213 which should have been allowed from 1/29/02 through 3/22/02. In other words, once a week office visit code at the 99213 level from 1/29/02 through 3/22/02 were in my opinion considered reasonable and medically necessary. I will provide a rationale below for all of my determinations. All other services rendered and billed from 1/28/02 onward were not reasonable or medically necessary except for the once per week office visits at the 99213 level. I also agree with the insurance carrier that the hot/cold cryotherapy unit as well as the treatment pads which were prescribed on 6/5/02 through 6/7/02 were not reasonable, medically necessary, or supported by the documentation.

Rationale/Basis for Decision

I certainly understand that the claimant fell from a significant height to the ground; however, the documentation reveals the claimant sustained no fractures and had probably sustained an aggravation of a pre-existing cervical and lumbar spine degenerative condition. The claimant's knee was also noted to be degenerated to some degree and he probably aggravated this. The knee MRI did not show the presence of significant internal derangement and that he would probably not be considered a surgical candidate with respect to his knee. I understand the significance of the injuries; however, prolonged chiropractic management of an injury such as this is not indicated regardless of the severity of the injury. The ankle MRI was also essentially normal, only showing mild evidence of sprain/strain injury. The documentation reveals that the claimant was injured on 10/18/01 and was able to convalesce for about 6 weeks before beginning active chiropractic care. Actual active chiropractic care did not begin, as documented, until 12/3/01. The evidence based Official Disability Guidelines 2003 issue recommends up to 18 visits over a 6-8 week period for treatment of cervical and lumbar intervertebral disc syndrome without myelopathy and radiculopathy syndromes, and anywhere from 9-12 visits of physical therapy for knee internal derangement problems as well as knee and wrist sprain/strain injuries. I will agree that some gradual objective improvements were documented in the chiropractic documentation; however, the month to month improvements over a 6 month period were minimal and did not beat or surpass the natural history of the injuries sustained. In other words, the provided chiropractic treatment did not progress the claimant any faster than had the claimant had no treatment at all or had he been seen for a few weeks of active care and then been transferred into a home based exercise program. Many of the therapeutic activities and exercises and kinetic activities were documented to have been of the stretching and active movement against gravity type. These could have been taught to the claimant and he could have been instructed over an 8 week period with transition into a home based exercise program and the same results would have likely occurred. Slow gradual improvement does not justify prolonged treatment. It is not proper patient management to run the claimant through 54 documented visits of physical therapy through 3/22/02 and then decide to refer the claimant out for orthopedic opinions. The documentation also revealed the need for continued electrical muscle stimulation home unit well past the acute stage of the injury. This is indicative in my opinion that the claimant was still in a significant amount of pain despite voluminous amounts of active physical therapy and chiropractic manipulation. Also, please consider the physician's report of 2/14/02 which states the claimant was still ambulating with the use of a cane and was antalgic after over 10 weeks of chiropractic treatment. I do not deny that the claimant had pain; however, the

evidence based and consensus based guidelines recommend referral in the presence of ongoing pain and dysfunction. The prescription for DME to include a hot/cold cryotherapy unit and treatment pads that were prescribed on 6/5/02 through 6/7/02 were in my opinion not reasonable or medically necessary as routine use of a $10 ice or heat pack would have sufficed. I certainly understand that the claimant had just had surgery about 2-3 weeks prior to the prescriptions that were written on 6/5/02 through 6/7/02; however, a form letter in support of DME is not acceptable in this case. There is no documented support and rationale to support the use of the 99070 code. It appears this was used for either electric stimulator pads of a 4 ounce package of analgesic cream. This was billed on virtually every visit and would not be considered cost effective or reasonable or medically necessary. I feel that office visits once per week beyond 1/28/02 by the chiropractor were reasonable and medically necessary. As the treating physician of record, the chiropractor would need to see the claimant in my opinion once per week to help coordinate care and to document how the claimant was doing. Therefore, it is my opinion that the routine use of the office visit code, which in this case was 99213, was reasonable and medically necessary from 1/29/02 through 3/22/02. The chiropractor stated the physical therapy was no longer needed or was actually stopped as of 3/22/02. On 3/22/02, the chiropractor stated that conservative care had been exhausted and physical therapy was formally discontinued. By this time the claimant had 54 visits which is about 3 times the recommended amount of visits for this type of injury. The once per week office visits beyond 3/22/02 were not considered reasonable or medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 2nd day of April 2003.