

MDR Tracking Number: M5-03-0984-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 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 12-16-02.

The IRO reviewed chiropractic treatment rendered from 2-15-02 to 5-16-02 that were denied based upon “V”.

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	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
2-15-02 2-18-02 2-20-02 2-22-02 3-8-02 3-15-02 3-18-02 3-20-02 3-25-02	97110 (8 units)	\$280.00	\$0.00	V	\$35.00 / 15 min	Section 408.021(a)	IRO concluded that treatment was medically necessary; therefore, reimbursement is recommended of 9 X \$280.00 = \$2520.00.
2-15-02 2-18-02 2-20-02 2-22-02 3-8-02 3-11-02 3-13-02 3-15-02 3-18-02 3-20-02 3-25-02 3-27-02 4-3-02 4-5-02 4-8-02 4-10-02	97150	\$27.00	\$0.00	V	\$27.00	Section 408.021(a)	IRO concluded that treatment was medically necessary; therefore, reimbursement is recommended of 16 X \$27.00 = \$432.00.
2-18-02 2-18-02 2-20-02 2-22-02	99213	\$50.00	\$0.00	V	\$48.00	Section 408.021(a)	IRO concluded that treatment was medically necessary; therefore, reimbursement is recommended of 7 X \$48.00 = \$336.00.

3-8-02 3-11-02 3-13-02								
2-18-02 2-18-02 2-20-02 2-22-02 3-8-02 3-11-02 3-13-02	97265	\$43.00	\$0.00	V	\$43.00	Section 408.021(a)	IRO concluded that treatment was medically necessary; therefore, reimbursement is recommended of 7 X \$43.00 = \$301.00.	
2-18-02 2-18-02 2-20-02 2-22-02 3-8-02 3-11-02 3-13-02	97250	\$43.00	\$0.00	V	\$43.00	Section 408.021(a)	IRO concluded that treatment was medically necessary; therefore, reimbursement is recommended of 7 X \$43.00 = \$301.00.	
3-11-02 3-13-02 4-8-02 4-10-02	97110 (5 units)	\$175.00	\$0.00	V	\$35.00 / 15 min	Section 408.021(a)	IRO concluded that treatment was medically necessary; therefore, reimbursement is recommended of 4 X \$175.00 = \$700.00.	
3-27-02 4-3-02 4-5-02	97110 (4 units)	\$140.00	\$0.00	V	\$35.00 / 15 min	Section 408.021(a)	IRO concluded that treatment was medically necessary; therefore, reimbursement is recommended of 3 X \$140.00 = \$420.00.	
TOTAL		\$5010.00						The requestor is entitled to reimbursement of <b>\$5010.00</b> .

The IRO concluded that therapeutic exercises and group therapeutic procedures were medically necessary. The IRO concluded that 4 weeks of passive physical therapy were medically necessary. Passive therapy beyond 4 weeks was not medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees (\$5010.00). Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for 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:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
1-23-02 3-5-02	97750MT (4 units)	\$172.00	\$43.00 \$43.00	F	\$43.00 / body area	Medicine GR (I)(E)(3)	Physical capacity testing of lumbar spine is supported. Insurance carrier reimbursed the provider appropriately.
1-25-02 3-7-02	97750MT (3 units)	\$129.00	\$43.00 \$0.00	F	\$43.00 / body area	Medicine GR (I)(E)(3)	Muscle testing supports 2 body areas tested; therefore, additional reimbursement of \$43.00 for each date is recommended = \$86.00.
1-28-02 1-30-02 2-1-02 2-4-02 2-6-02 2-8-02	97150	\$27.00	\$0.00	F	\$27.00	CPT Code Description	SOAP notes support billed service. Reimbursement is recommended of 6 dates X \$27.00 = \$162.00.
2-4-02	97265	\$43.00	\$0.00	F	\$43.00	CPT Code Description	SOAP note support billed service. Reimbursement is recommended of \$43.00.
2-4-02	97250	\$43.00	\$0.00	F	\$43.00	CPT Code Description	SOAP note support billed service. Reimbursement is recommended of \$43.00.
3-7-02	99070	\$6.00	\$0.00	F	DOP	General Instructions GR (IV)	SOAP note support billed service. Reimbursement is recommended of \$6.00.
TOTAL							The requestor is entitled to reimbursement of <b>\$340.00</b> .

**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 1-23-02 through 5-16-02 in this dispute.

This Order is hereby issued this 19th day of September 2003.

Roy Lewis, Supervisor  
 Medical Dispute Resolution  
 Medical Review Division

February 24, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M5-03-0984-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

It is noted that \_\_\_ sustained an acute traumatic work-related injury on \_\_\_. The mechanism of injury is stated as a trip and fall in the schoolyard. The documentation denotes that she fell on her right side and inverted her foot slightly. Initially, she denied rotation. The history did denote a prior work comp injury for her back. There were no significant clinical findings or neuro-deficits noted initially. X-rays showed some mild DJD for this 56-year-old, 5'6", 180 lb. Female. Initial diagnosis was a mile strain. Later a MRI showed an minimal disc bulge suggested at L4/5 in the posterior lateral regions. Documentation from \_\_\_ starts on 1/22/02 with an initial report on 1/23/-2. His report does not denote a prior work-related back injury. An exam showed no neuro-deficints, but rather showed mostly palpatory pain and tenderness with limited range of motion. Some positive provocative orthopedic maneuvers and a 30° difference between sitting and supine SLR were noted. This is a positive Waddell's finding. That, along with a positive Libman's, accounts for the patient's unreasonably high VAS. The remaining testing is based on isometric muscle testing. Diagnoses given were lumbar sprain/strain grade II, lumbar facet syndrome and myofascial syndrome. Treatment noted included mobilization, soft tissue, exercise and 2 units of diatheramy (May 7<sup>th</sup> and 16<sup>th</sup>). Manipulation is not noted on any of the office notes or billing. Documentation denotes care by \_\_\_ from 1/22/02 through 5/16/02 for approximately 38 office visits with 26 treatments.

## DISPUTED SERVICES

Under dispute are office visits, joint mobilization, myofascial release, therapeutic exercise, group therapy procedures and diathermy provided to \_\_\_ from 12/18/02 through 5/16/02.

## DECISION

The reviewer both agrees and disagrees with the prior adverse determination.

The reviewer finds medical necessity for active care (therapeutic exercises and group therapy procedures) for the duration of treatment and also for 4 weeks of passive therapy (myofascial release).

The reviewer does not find medical necessity for passive therapy (myofascial release) beyond 4 weeks, diathermy and office visits without manipulation.

## BASIS FOR THE DECISION

As noted above, there were 38 visits, none of which indicate the “-MP” as required if manipulation was included. The documentation presented does not support the medical necessity of office visits only without manipulation just to monitor the administration of therapy. Without manipulation, it just becomes a review of therapy, which has clear limitations. Passive therapy (myofascial release) that continues past 4 weeks is excessive and counterproductive. There is no medical necessity for the use of diathermy this late in the case. The most appropriate care is that of active care. Simple, uncomplicated cases of similar diagnoses will usually resolve within 8-12 weeks with physical medicine. This case has several significant complicating factors and other minor ones including prior history of back injury, pre-existing degenerative changes, age of 56 years, 181 pounds, and a low pain tolerance. These entities will double normal uncomplicated cases with similar diagnoses. Therefore, duration of this case is not unreasonable considering the complicating factors. Through active care (therapeutic exercises and group therapy procedures) in this case, modest improvement was shown. It therefore meets the criteria for medical necessity.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee’s policy

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,