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

SOAH DOCKET NO. 453-04-0996.M5

MDR Tracking Number: M5-03-0992-01

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 12-6-02.

The IRO reviewed chiropractic treatment, supplies and muscle testing rendered from 1-3-02 to 3-14-02 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
1-16-02 2-8-02 2-13-02 2-15-02 2-20-02 2-21-02	97110 (8 units)	$280.00	$0.00	U	$35.00 / 15 min	Section 408.021(a)	IRO concluded that treatment was medically necessary. Reimbursement is recommended of 6 dates X $280.00 = $1680.00.
1-16-02 1-18-02 2-13-02 2-15-02 2-20-02	97265	$43.00	$0.00	U	$43.00	Section 408.021(a)	IRO concluded that treatment was medically necessary. Reimbursement is recommended of 5 dates X $43.00 = $215.00.
1-18-02 1-21-02 1-23-02 1-25-02 2-8-02 2-13-02 2-15-02 2-20-02 2-21-02 3-14-02	99213	$50.00	$0.00	U	$48.00	Section 408.021(a)	IRO concluded that treatment was medically necessary. Reimbursement is recommended of 10 dates X $48.00 = $480.00.
1-18-02 1-23-02	97110 (4 units)	$140.00	$0.00	U	$35.00 / 15 min	Section 408.021(a)	IRO concluded that treatment was medically necessary. Reimbursement is recommended of 2 dates X $140.00 = $280.00.
1-21-02 1-25-02	97110 (7 units)	$245.00	$0.00	U	$35.00 / 15 min	Section 408.021(a)	IRO concluded that treatment was medically necessary. Reimbursement is recommended of 2 dates X $245.00 = $490.00.
2-15-02 2-20-02	97150	$27.00	$0.00	U	$27.00	Section 408.021(a)	IRO concluded that treatment was medically necessary. Reimbursement is recommended

							of 2 dates X $27.00 = $54.00.
TOTAL		$794.75					The requestor is entitled to reimbursement of **$3199.00.**

The IRO concluded that therapeutic exercises, joint mobilization, office visits and group therapeutic procedure provided from 1-3-02 through 3-14-02 were medically necessary. The IRO concluded that analgesic balm, Delorme muscle testing, myofascial release and electrical stimulation provided from 1-3-02 through 3-14-02 were not medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees ($3199.00). 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	MAR$ (Maximum Allowable Reimburse-ment)	Reference	Rationale
1-3-02	992-15	$125.00	$0.00	F	$103.00	Evaluation & Management GR (IV)	Office visit report supports level of service billed per MFG, reimbursement is recommended of $103.00.
1-3-02	95851	$40.00	$0.00	G	$36.00	Medicine GR (I)(E)(4)	Range of Motion testing is not global to office visit; therefore, reimbursement of $36.00 is recommended.
1-3-02	97750MT	$43.00	$0.00	G	$43.00	Medicine GR (I)(E)(3)	Muscle testing is not global to office visit; therefore, reimbursement of $43.00 is recommended.
3-12-02	99080 (139)	$69.50	$0.00	G	$0.50 /page	Rule 133.106	139 pages were sent to Designated Doctor, reimbursement of $69.50 is recommended.
3-14-02	99070	$18.00	$11.00	M	DOP	General Instructions GR (III) Section 413.011(b)	The requestor did not support position that amount billed was fair and reasonable per statute; therefore, reimbursement is not

							recommended.
3-14-02	99070	$55.50	$0.00	R	DOP	General Instructions GR (III)	Lumbar support – the insurance carrier filed a TWCC-21 disputing the back as not related to ankle injury.
TOTAL	$794.75		The requestor is entitled to reimbursement of **$251.50.**				

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

Elizabeth Pickle
Medical Dispute Resolution Officer
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 1-3-02 through 3-14-02 in this dispute.

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

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

March 19, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE:
MDR Tracking #: M5-03-0992-01
IRO Certificate #: 4326

___ 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 rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional 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

This patient sustained a work-related injury on ___ when she got out of a large truck and twisted her right ankle. X-rays were negative for a fracture and the patient was diagnosed with ligamentous instability. On 01/29/01, she underwent a lateral ligamentous reconstruction of her right ankle using the peroneus brevis tendon. An open draining wound that eventually healed complicated her post-operative period. The patient continued to complain of pain and was under the care of a chiropractor from 01/03/02 through 03/14/02. During that time, she received analgesic balm, Delorme muscle testing, therapeutic exercises, electrical stimulation, myofascial release, joint mobilization, office visits and group therapeutic procedure.

Requested Service(s)

Analgesic balm, Delorme muscle testing, therapeutic exercises, electrical stimulation, myofascial release, joint mobilization, office visits and group therapeutic procedure provided from 01/03/02 through 03/14/02.

Decision

It is determined that the therapeutic exercises, joint mobilization, office visits and group therapeutic procedures provided from 01/03/02 through 03/14/02 were medically necessary to treat this patient's condition.

It is determined that the analgesic balm, Delorme muscle testing, myofascial release, and electrical stimulation provided from 01/03/02 through 03/14/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The chiropractor diagnosed the patient with right ankle sprain/strain and myofascial pain syndrome. She was treated for two months and was then referred to a surgeon for reconstruction of the right lateral ligaments of the ankle. She underwent computerized muscle strength testing on 10/04/01 and was off of work from 10/04/01 through 12/04/01. She was re-evaluated on 01/03/02 and computerized muscle testing revealed that she was functioning at the sedentary-light physical demand level and there was no progress in her ankle strengthening. She was taken off work from 01/03/02 to 02/10/02 and also underwent Delorme muscle testing of the lumbar muscles, leg extensors, leg flexors and calf raises on 01/14/02 and 02/05/02.

The medical record documentation revealed that the patient had a substantial reduction in her ankle range of motion and strength over the course of her treatment and she had a protracted period of inactivity after her 01/29/01 surgical interventions and was attempting to manage her condition through home exercises. The

strength testing and range of motion evaluations performed indicated that the patient's home exercise program interventions were unsuccessful and a brief period of outpatient rehabilitation was indicated.

The medical record documentation contained no readily identifiable references to the use of the analgesic balm within the text reviewed nor did the documentation contain readily identifiable records pertaining to the use of electrical stimulation. However, it is generally accepted that the use of passive modalities is not indicated outside the acute phase of injury. Current treatment guidelines note that little current medical evidence is available to support the efficacy of passive procedures in the management of musculoskeletal injuries after the acute phase of care as referenced in "Philadelphia Panel Evidence-Based Guidelines, Physical Therapy, 2001; 81.

The Delorme muscle testing of the lumbar muscles and leg flexors/extensors was not medically necessary for the treatment of the patient as the muscles tested were in non-injured regions.

Haleman et al. indicate that it is beneficial to proceed to the rehabilitation phase of care as rapidly a 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 optimum result as referenced in Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993.

Therefore, the therapeutic exercises, joint mobilization office visits and group therapeutic procedures from 01/03/02 through 03/14/02 were medically necessary and the analgesic balm, Delorme muscle testing, myofascial release, and electrical stimulation provided from 01/03/02 through 03/14/02 were not medically necessary.

Sincerely,