

MDR Tracking Number: M5-03-1517-01

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 2-14-03.

The IRO reviewed chiropractic treatment rendered from 2-19-02 through 5-7-02 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. 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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** 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 July 15, 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.

On 9-16-02, Hearing Officer \_\_\_ concluded that the claimant sustained a compensable injury on \_\_\_. The insurance carrier was ordered to pay medical and income benefits related to compensable injury. Therefore, the insurance carrier's denial of payment based upon "E" is resolved and services will be reviewed in accordance with MFG.

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
2-18-02	99214MP	\$71.00	\$0.00	E, F	\$71.00	Medicine GR (I)(B)(1)(b)	SOAP note supports service billed, reimbursement of \$71.00 is recommended.
2-18-02	72010	\$240.00	\$0.00	E, F	\$111.00	Rule 133.307(g)(3)(B)	X-ray report was not submitted to support fee dispute, no reimbursement is recommended.
2-18-02	97014	\$30.00	\$0.00	E, F	\$15.00	CPT code	SOAP note supports service

2-20-02 3-8-02 3-11-02 3-12-02 3-14-02 5-14-02						descriptor	billed, reimbursement of 7 dates X \$15.00 = \$105.00 is recommended.
2-18-02	99080-73	\$15.00	\$0.00	E, F	\$15.00		TWCC-73 report supports service billed per MFG, reimbursement of \$15.00 is recommended.
2-20-02 2-25-02 3-8-02 3-11-02 3-12-02 3-14-02 5-9-02 5-14-02 5-16-02 5-22-02 5-24-02 5-30-02 6-3-02 6-24-02 7-2-02 7-9-02	99213MP	\$55.00	\$0.00	E, F	\$48.00	Medicine GR (I)(B)(1)(b)	SOAP note supports service billed, reimbursement of 16 dates X \$48.00 = \$768.00 is recommended.
2-20-02	97035	\$25.00	\$0.00	E, F	\$22.00 / 15 min	CPT Code Descriptor	SOAP note supports billed service, reimbursement per MFG of \$22.00 is recommended.
2-20-02 2-25-02	97039	\$30.00	\$0.00	E, F	DOP	General Instructions GR (III)	DOP not met per MFG, SOAP note does not indicate what service was billed as 97039; therefore, no reimbursement is recommended.
2-25-02 3-8-02 3-11-02 3-12-02	97124	\$30.00	\$0.00	E, F	\$28.00	CPT Code Descriptor	SOAP note supports billed service, reimbursement per MFG of \$22.00 is recommended.
3-8-01 3-12-02 3-14-02	97012	\$25.00	\$0.00	E, F	\$20.00	CPT Code Descriptor	SOAP note supports billed service, reimbursement per MFG of 3 dates X \$20.00 = \$60.00 is recommended.
3-11-02 3-12-02 3-14-02	97024	\$25.00	\$0.00	E, F	\$21.00	CPT Code Descriptor	SOAP note supports billed service, reimbursement per MFG of 3 dates X \$21.00 = \$63.00 is recommended.

3-29-02	97110	\$35.00	\$0.00	E, F	\$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	SOAP note does not support exclusive one to one supervision per MFG, no reimbursement is recommended.
5-30-02	99080-73	\$15.00	\$0.00	E, F	\$15.00	Rule 129.6(d)	TWCC-73 supports service billed, reimbursement is recommended of \$15.00.
5-14-02	99070	\$10.00	\$0.00	E, F	DOP	General Instructions GR (IV)	SOAP note does not indicate what supply was billed; therefore, no reimbursement is recommended.
TOTAL							The requestor is entitled to reimbursement of <b>\$1141.00.</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 2-19-02 through 7-9-02 in this dispute.

This Decision and Order is hereby issued this 25<sup>th</sup> day of November 2003.

Elizabeth Pickle  
 Medical Dispute Resolution Officer  
 Medical Review Division

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

July 3, 2003

**Re: IRO Case # M5-03-1517**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

#### History

The patient injured his neck on \_\_\_ when he was struck in the face by another individual and fell to the ground. Chiropractic treatment was initiated. He has been treated with chiropractic and physical therapy, and an MRI and nerve conduction tests were obtained.

#### Requested Service(s)

Office visits with manipulation, unlisted modality, electrical stimulation, ultrasound, supplies, traction, diathermy, massage, therapeutic procedure, special reports 2/19/02 – 5/7/02

#### Decision

I agree with the carrier's decision to deny the requested treatment.

#### Rationale

The patient had extensive chiropractic treatment with little, if any, documented relief of his symptoms. The documentation provided for this review is of poor quality, is sometimes illegible and lacks objective quantifiable findings to support the necessity of treatment. Two physicians concluded that the patient had bilateral carpal tunnel syndrome that was unrelated to the \_\_\_ injury. The documentation does not show that the treating chiropractor diagnosed the carpal tunnel syndrome. It is well documented in medical literature that a "double crush phenomenon" can result when CTS and neck pain are coexistent, the neck pain resulting from the CTS. Thus the neck pain would not respond to treatment unless the CTS were addressed. Determining causation is beyond this review. It is my opinion, however, that the chiropractic treatment in dispute was ineffective, unreasonable and unnecessary because the chiropractor failed to address the CTS. The documentation provided for review shows that there was considerable treatment given to the shoulders, yet in the 2/20/03 Required Medical Examination Report, the examiner stated that "there are no current objective medical findings to suggest ongoing pathology of the shoulder joints."

In the treating chiropractor's documentation of 3/1/02 it is stated that "epicondylitis improving" with therapy in the form of inferential, cold packs and diathermy. The treatment, however, was ineffective because it failed to treat the source of the elbow pain, CTS.

I question the continued and extensive manipulation of the cervical spine with confirmed C4-5 disk extrusion and C3-4 disk protrusion. The chiropractor failed to show that manipulation of the cervical spine was necessary. It was over-utilized, inappropriate and possibly iatrogenic. From the documentation presented for this review, it is my opinion that the treatment in dispute was unreasonable and ineffective in relieving symptoms or improving function.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,