MDR Tracking Number: M5-03-2266-01

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 05-09-03.

The IRO reviewed physical performance test, office visits, joint mobilization, myofasical release, neuromuscular re-education, office visits with manipulations, therapeutic activities, range of motion testing, and data analysis rendered from 02-14-03 through 03-17-03 that were denied based upon “U”.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for physical performance test, office visits, joint mobilization, myofasical release, neuromuscular re-education, office visits with manipulations, therapeutic activities, range of motion testing, and data analysis. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 03-17-04, 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 Reimbursement)	Reference	Rationale
01-10-03	95851	$72.00 (2 units)	0.00	G	$36.00 per unit	MFG MGR (I)(E)(4)	Range of motion (95851) is not global to any other service billed on this date Recommended Reimbursement $72.00 ($36.00 for 2 units)
01-21-03	97122	$35.00	0.00	F	$35.00	MFG MGR (I)(A)(10)(a)	Relevant information was not submitted for date of service to

							support services rendered therefore reimbursement is not recommended
TOTAL		$107.00					The requestor is entitled to reimbursement of **$72.00**

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 date of service 01-10-03 in this dispute.

This Decision is hereby issued this 7th day of May 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

July 29, 2003

MDR Tracking #: M5-3-2266-01
IRO Certificate #:IRO 4326

The ___ 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. ___'s 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 fell down a flight of stairs on ___ injuring her low back, neck, left shoulder, and both knees. She saw a chiropractor for treatment and physical therapy.

Requested Service(s)

Physical performance test, office visits, joint mobilization, myofascial release, neuromuscular re-education, therapeutic procedure, office visits with manipulation, therapeutic activities, range of motion testing, and data analysis from 02/14/03 through 03/17/03

Decision

It is determined that the physical performance test, office visits, joint mobilization, myofascial release, neuromuscular re-education, therapeutic procedure, office visits with manipulation, therapeutic activities, range of motion testing, and data analysis from 02/14/03 through 03/17/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The necessity for continued clinically supervised conservative therapeutic applications has not been established. The patient has mild pathology established on the 01/23/03 MRI, but a clinical correlation has not been sufficiently established. The patient has been under conservative treatment for over five months. The patient sustained musculoskeletal injuries in her ___ accident, but a continued course of conservative unidisciplinary treatment at this time was not warranted from the reviewed documentation.

It is vital to the management of the patient that functional data be collected and analyzed on a regular basis to determine if the applied therapeutic trials show any benefit to the patient's medical condition. The records provided do not show that the patient received any benefit from the therapeutics that were applied from 02/14/03 through 03/17/03.

A true pain generator has not been established. It is not clear from the reviewed medical file if the patient underwent any invasive pain controls like epidural steroid or trigger point injections. It is vital to the management of this patient that a full functional capacity evaluation be performed so that current and accurate limitations can be placed on this patient if applicable. Conservative unidisciplinary chiropractic and physical therapy treatment applications have been exhausted and are no longer appropriate to treat this patient's medical condition. Therefore, it is determined that the physical performance test, office visits, joint mobilization, myofascial release, neuromuscular re-education, therapeutic procedure, office visits with manipulation, therapeutic activities, range of motion testing, and data analysis from 02/14/03 through 03/17/03 were not medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- Levoska S, Keinanen-Kiukaanniemi S. *Active or passive physiotherapy for occupational cervicobrachial disorders? A comparison of two treatment methods with a 1-year follow-up.* Arch Phys Med Rehabil. 1993 Apr;74(4):425-30.

- *Unremitting low back pain. In: North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialists.* North American Spine Society (NASS); 2000. 96p.

Sincerely,