MDR Tracking Number: M5-03-3065-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 7-24-03.

The IRO reviewed office visits w/manipulations, electrical stimulation, hot/cold packs, ultrasound, neuromuscular stimulator, therapeutic activities, and massage from 8-23-02 through 10-22-02.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO agreed with the carrier's previous determination that the office visits w/ manipulations, electrical stimulation, hot/cold packs, ultrasound, neuromuscular stimulator, and massage therapy from 8-23-02 through 8-30-02, and 9-10-02 through 10-22-02 were **not** medically necessary. The IRO concluded that the therapeutic activities from 8-23-02 through 8-30-02 were medically necessary. 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 10-13-03, 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.

CPT code 99213-MP for dates of service 9-5-02 and 9-17-02 were coded as "S – supplemental payment made." On 1-22-04, the requestor submitted a letter to confirm receipt of payment and subsequently withdrew these two dates of service.

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 Order is applicable for dates of service 8-23-02 through 8-30-02 in this dispute.

This Order is hereby issued this 3rd day of February 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION **Amended Letter**

Note: Decision

October 2, 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 #: M5-03-3065-01
IRO Certificate #: IRO 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 an injury to his left shoulder on ___ when lifting a large trash container. He saw a chiropractor for treatment and therapy. A left shoulder MRI dated 08/16/02 revealed a small tear of the distal supraspinatus tendon.

Requested Service(s)

Therapeutic activities from 08/23/02 through 08/30/02, and office visits with manipulation, electrical stimulation, hot or cold packs, ultrasound, neuromuscular stimulator, massage therapy, from 08/23/02 through 08/30/02, 09/10/02, 09/13/02, 09/24/02, 09/26/02, and 10/03/02 through 10/22/02

Decision

It is determined that the therapeutic activities from 08/23/02 through 08/30/02 were medically necessary to treat this patient's condition. However, the office visits with manipulation, electrical stimulation, hot or cold packs, ultrasound, neuromuscular stimulator, and massage therapy from 08/23/02 through 08/30/02, 09/10/02, 09/13/02, 09/24/02, 09/26/02, and 10/03/02 through 10/22/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision
The patient went to the chiropractor for evaluation and treatment on 07/09/02 following his ___work-related injury. He complained of left shoulder and mid-back pain and the examination revealed paraspinal spasms and reduced ranges of motion in the left shoulder and thoracic regions. Radiographs were taken of the upper back and shoulder and the patient was diagnosed with traumatic shoulder arthropathy, unspecified arthropathy shoulder, shoulder joint derangement, thoracic sprain/strain, and thoracic joint dysfunction. The patient was prescribed a home electrical muscular stimulator (EMS) on 08/23/02.

The use of manipulation was not medically necessary from 08/23/02 through 08/30/02, 09/10/02, 09/13/02, 09/24/02, 09/26/02, and 10/03/02 through 10/22/02. The maximum therapeutic benefits associated with manipulation are noted the first few weeks of treatment and the protracted use of manipulation after the first four to six weeks of care does not lead to additional therapeutic benefits. Haldeman et al indicated that most cases resolve well within six weeks of intervention, which is consistent with the expectations from natural history *(Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993, p. 121).*

Triano studied the differences in treatment history with manipulation for acute, subacute, and recurrent spine pain and found that all but 25 (10.37%) of the original 241 patients in the study had their conditions resolve in six weeks or less *(Triano, J.J., et al, "Differences in treatment history with manipulation for acute, subacute, chronic, and recurrent spine pain", JMPT, 15:24-30, 1992).* Haldeman reported that manipulation appears to have its greatest effect immediately following treatment and during the initial two to six weeks of ongoing treatment. Haldeman noted that the effectiveness of manipulation for the management of back pain seems to be minimal at three months to 12 months *(Haldeman, S. "Spinal manipulative therapy: A status report:, Clinical Orthopedics and Related Research, 179:62-70, 1983).*

The use of massage therapy, ultrasound, hot or cold packs, neuromuscular stimulator, and electrical stimulation were not medically necessary from 08/23/02 through 08/30/02, 09/10/02, 09/13/02, 09/24/02, 09/26/02, and 10/03/02 through 10/22/02. According to the Philadelphia Panel's Evidence-Based Guidelines on Selected Rehabilitation Interventions for Shoulder Pain' none of the modalities used in the treatment of the patient were supported by the study. Ultrasound provided clinically important pain relief relative to a control for patients with calcific tendonitis in the short term (less than two months). There was good agreement with this recommendation from practitioners (75%). For several interventions and indications (e.g., thermotherapy, therapeutic ultrasound, massage, electrical stimulation), there was a lack of evidence regarding efficacy. *("Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Shoulder Pain". Phys Ther. 2001; 81:1719-1730).* Therefore, it is determined that the therapeutic activities from 08/23/02 through 08/30/02 were medically necessary to treat this patient's condition. However, the office visits with manipulation, electrical stimulation, hot or cold packs, ultrasound, neuromuscular stimulator, and massage therapy from 08/23/02 through 08/30/02, 09/10/02, 09/13/02, 09/24/02, 09/26/02, and 10/03/02 through 10/22/02 were not medically necessary.

Sincerely,