MDR Tracking Number: M5-03-3096-01

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 7-28-03.

The IRO reviewed range of motion, therapeutic procedures, myofascial release, office visits, joint mobilization, and manual traction from 5-5-03 through 5-27-03 and 6-3-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the medical necessity issues. The IRO concluded that the range of motion, office visits, and therapeutic procedures **were** medically necessary. The IRO agreed with the previous determination that the manual traction, myofascial release, and joint mobilization **were not** medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

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 10-10-03, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Max. Allowable Reimbursement)**	**Reference**	**Rationale**
2-24-03	97110	$140.00	$35.00	F	$35.00 ea 15 min	Rule 133.307(g)(3)(A-F)	See RATIONALE below. No reimbursement recommended.
3-5-03	97110	$140.00	$0.00	F, M456	$35.00 ea 15 min	Rule 133.307(g)(3)(A-F)	Carrier denied as F, M456 – the maximum number of physical therapy services has been exceeded for this date of service." The charge for physical medicine treatment shall not exceed any combination of four modalities (codes 97010 through 97541). Per the bill and EOB, requestor billed for code 97139-TN. This code is not included in the combination of four modalities; therefore, this denial code does not apply. Code 97110 will be reviewed per the 1996 *Medical Fee Guideline.* See RATIONALE below. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
3-31-03	99213	$48.00	$0.00	D	$48.00	Rule 133.307(g)(3)(A-F)	Neither party submitted the original EOB; therefore, the review will be per the MFG. Relevant information supports delivery of service. Recommend reimbursement of $48.00
6-2-03	99213	$48.00	$0.00	No EOB	$48.00	Rule 133.307(g)(3)(A-F)	Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.
TOTAL		$376.00	$35.00				The requestor is entitled to reimbursement of $48.00.

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

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 3-31-03 through 6-3-03 in this dispute.

This Order is hereby issued this 26th day of March 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

September 25, 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 #: M5-03-3096-01
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 sustained a back injury on ___ along with a left inguinal hernia, mechanism unknown. An MRI dated 02/27/03 revealed a disc herniation at L4-5 without impingement and a small bulge at L5-S1. He saw a chiropractor for treatment and therapy and eventually had his left inguinal hernia repaired surgically on 04/09/03.

Requested Service(s)

Range of motion, therapeutic procedures, myofascial release, office visits, joint mobilization, and manual traction from 05/05/03 through 05/27/03 and 06/03/03

Decision

It is determined that the range of motion, office visits, and therapeutic procedures from 05/05/03 through 05/27/03 and 06/03/03 were medically necessary to treat this patient's condition. However, the manual traction, myofascial release, and joint mobilization from 05/05/03 through 05/27/03 and 06/03/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

A review of the medical records revealed that the patient received joint mobilization, manual traction, and myofascial release from the onset of treatment and the protracted use of these passive treatments were not medically necessary. A review of the patient's self-reported pain scores revealed that his pain related to his lower back changed little over the course of his treatment.

Current chiropractic treatment guidelines indicate that the protracted use of manipulation and manual procedures is not indicated in the presence of nonresponsiveness of the patient to the care rendered. An adequate trial of care is identified as a course of two weeks each of different types of manual procedures (4 weeks total), after which, in the absence of documented improvement, manual procedures are no longer indicated *(Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaitherburg, Maryland, 1993).* The patient had a protracted course of care in excess of the parameters delineated by the above-mentioned document and has not demonstrated a favorable response to treatment.

Chiropractic literature indicates that little is to be gained from prolonged courses of chiropractic care if there has not been adequate response in the first month of care. Bronfort *(Bronfort, G., "Chiropractic treatment of low back pain: A prospective survey", JMPT, 9:99-113, 1986)* found that there was little improvement occurring in patients who responded poorly to the first month of care. The maximum benefits of manipulation are realized in the first month of care in the majority of patients, with diminishing returns after the first month of treatment.

The use of myofascial release was not medically necessary. The Philadelphia Panel found that therapeutic exercises were found to be beneficial for chronic, subacute, and post-surgery low back pain. Continuation of normal activities was the only intervention with beneficial effects for acute low back pain. 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 Low Back Pain". Physical Therapy. 2001;81:1641-1674).*

The use of therapeutic exercises was consistent with treatment guidelines for the management of lower back disorders. Haldeman et al indicate that it is beneficial to proceed to the rehabilitation phase of care as rapidly as 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 the optimum result. *(Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993).*

The range of motion testing was medically indicated for objective documentation of the patient's condition related to his work injury. Therefore, it is determined that the range of motion, office visits, and therapeutic procedures from 05/05/03 through 05/27/03 and 06/03/03 were medically necessary. However, the manual traction, myofascial release, and joint mobilization from 05/05/03 through 05/27/03 and 06/03/03 were not medically necessary.

Sincerely,