MDR Tracking Number: M5-03-3317-01

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 8-18-03.

The IRO reviewed electrodes, office visits, massage therapy, group therapeutic procedures, neuromuscular re-education, ultrasound, joint mobilization, training for daily living, electrical stimulation, gait training, and hot/cold packs from 7-17-02 through 10-21-02.

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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 10-23-03, 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	Reference	Rationale
7/17/02	99204	$106.00	$0.00	D	Rule 133.307(g)(3)(A-F)	Neither party submitted the original EOB; therefore, this review will be per the 96 MFG. Relevant information does not support level of service. No reimbursement recommended.
7/17/02 8/19/02	99080	$15.00 ea DOS	$0.00	F		Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	Reference	Rationale
7/19/02	99212	$32.00	$0.00	F		Relevant information supports delivery of service. Recommend reimbursement of $32.00.
7/18/02 7/19/02 7/24/02 8/19/02	99212	$32.00 ea DOS	$0.00	D		Neither party submitted the original EOB; therefore, this review will be per the 96 MFG. Relevant information supports delivery of service. Recommend reimbursement of $128.00.
7/17/02 7/18/02 7/19/02 7/22/02 7/24/02 8/19/02	97032 97124 97035 97010 97265 97112	$22.00 ea DOS $28.00 ea DOS $22.00 ea DOS $11.00 ea DOS $43.00 ea DOS $35.00 ea DOS	$0.00	D	Rule 133.307(g)(3)(A-F)	Neither party submitted the original EOB; therefore, this review will be per the 96 MFG. Relevant information does not support delivery of service. No reimbursement recommended.
9/11/02	97150 97116 97124 97035	$27.00 $38.00 $28.00 $22.00	$0.00	No EOB		Relevant information does not support delivery of service. No reimbursement recommended.
9/11/02 9/13/02	99212	$32.00 ea DOS	$0.00	No EOB		Relevant information supports delivery of service. Recommend reimbursement of $64.00.
9/26/02	99071	$30.00	$0.00	F		Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.
10/17/02	99090	$108.00	$0.00	F		Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	Reference	Rationale
TOTAL		$1,579.00				The requestor is entitled to reimbursement of $224.00.

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 Order is applicable for dates of service 7/18/02 through 9/13/02 in this dispute.

This Order is hereby issued this 1st day of April 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division
October 14, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___

CLINICAL HISTORY

Available information suggests that this patient reports injury at work on ___ as a result of a slip and fall on a wet surface. The patient appears to present initially to a ___ where she was x-rayed, received medications, injections and physical therapy for head, lower back, leg and shoulder conditions. No specific reports are submitted from ___. The patient also is said to be seen concurrently by her family physician, which is unnamed. The patient appears to present to a chiropractor, ___, on 7/17/02 (___ post-injury), with complaints of lower back pain. No requests for previous medical records appear to be made.

There is some review of a 2/21/02 MRI study suggesting lumbar disc protrusion with spondylosis and foraminal narrowing at L3-L5 levels. Right ankle imaging suggests questionable subchondral cyst. Bilateral shoulder imaging suggests Tendonosis or tendonopathy of supraspinatus and subscapularis tendons without evidence of tear. Treatment plan appears to consist of multiple passive modalities without specific level, frequency or duration of care noted. There are multiple, unsigned, daily chiropractic notes submitted by another chiropractor, ___, DC, from 7/17/02 to 10/11/02. These notes appear to suggest that the patient is undergoing physical therapy treatment consisting of massage, ultrasound, hot packs, joint mobilizations, electric stimulation and gait training. Nerve conduction and EMG studies appear to be obtained on 8/29/02 by a ___, suggesting findings that are largely within normal limits. There is some suggestion of chronic reinnervation changes at the L5 level. These appear to be ordered by a 3rd chiropractor, ___. Additional appeals and submission requests are submitted by ___, DC, and ___ but there is no documentation in this file suggesting that these doctors were involved with evaluation and treatment of this patient. No physical therapy notes or FCE evaluations are submitted for review. Some blank, unsigned exercise forms are submitted from ___, dated 9/19/02, without explanation or rationale for application. Subsequent treatment plans appear essentially unchanged suggesting only that “patient will continue with present treatment plan.”

REQUESTED SERVICE (S)
Determine medical necessity for chiropractic services including (Electrodes A4556, massage therapy 97124, group therapeutic procedures 97150, Neuromuscular re-education 97112, ultrasound therapy 97035, joint mobilization 97265, training for daily living 97540, electric stimulation 97032, gait training 97116, hot and cold packs 97010) for dates in dispute 7/17/02 through 10/21/02.

DECISION
Medical necessity for these services is not supported by available documentation.

RATIONALE/BASIS FOR DECISION
At ___ post injury, clinical rationale for continuation of this level of passive and active physical therapy is not supported by natural history and/or generally accepted standards of care. In addition, treating chiropractor(s) do not appear to have made any specific review of physical therapy already obtained from previous providers. There is no specific outline of functional assessment, active therapeutic exercise protocols or self-care instruction. There is no documentation, specific orders or specific explanation of medical necessity for electrodes A4556, group therapeutic procedures, neuromuscular reeducation or training for daily living provided in items submitted.

1. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. J Manipulative Physiol Ther 2002; 25(1): 10-20.
2. Bigos S., et al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994. “The use of physical agents and modalities in the treatment of acute low back pain problems is of insufficiently proven benefit to justify their cost. As an option, patients may be taught self application of heat or cold to the back at home.”

3. Hoving JL, Koes BW, de Vet HCW, van der Windt DAWM, Assendelft WJJ, van Mameren H, et al. Manual therapy, physical therapy or continued care by a general practitioner for patients with back pain. A randomized, controlled trial. Ann Int Med 2002; 136:713-722.
4. Morton JE. Manipulation in the treatment of low back pain. J Man Manip Ther 1999; 7(4): 182-189.
5. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review.

This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute a per se recommendation for specific claims or administrative functions to be made or enforced.