MDR Tracking Number: M5-02-2778-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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.

The IRO reviewed a work hardening program rendered from 9-24-01 to 10-26-01 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.

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

On June 26, 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.

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

The request for medical dispute resolution was received in the Medical Review Division on 6-20-02; therefore, dates of service prior to 6-20-01 were submitted untimely per Rule 133.305.

Services that were denied with No EOB will be reviewed per *Medical Fee Guideline.*

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MAR$ (Maximum Allowable Reimbursement) | Reference | Rationale |
|---|---|---|---|---|---|---|---|
| 7-27-01<br>8-1-01<br>10-1-01<br>10-3-01<br>10-22-01<br>10-31-01 | 99213 | $48.00 | $0.00 | No EOB | $48.00 | Medicine GR (I)(B)(1)(b) | Documentation supports service billed. Reimbursement of 6 X $48.00 = $288.00 is recommended. |
| 8-3-01<br>8-8-01<br>8-10-01<br>8-15-01<br>8-24-01 | 99213 | $48.00 | $0.00 | N | $48.00 | Medicine GR (I)(B)(1)(b) | Documentation supports service billed. Reimbursement of 19X $48.00 = $912.00 is recommended. |

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|---|---|---|---|---|---|---|---|
| 8-29-01<br>8-31-01<br>9-4-01<br>9-5-01<br>10-17-01<br>10-19-01<br>10-22-01<br>10-24-01<br>11-2-01<br>11-5-01<br>11-7-01<br>11-9-01<br>11-12-01<br>11-14-01 | | | | | | | |
| 6-20-01<br>6-21-01<br>6-25-01<br>6-27-01<br>6-29-01<br>7-9-01<br>7-12-01<br>7-17-01<br>7-18-01<br>7-20-01<br>7-23-01<br>7-25-01<br>7-30-01 | 97032 | $22.00 | $0.00 | N | $22.00 | CPT code description | Electrical Stimulation Documentation supports service billed. Reimbursement of 13X $22.00 = $286.00 is recommended. |
| 7-9-01<br>7-11-01<br>7-12-01<br>7-17-01<br>7-18-01<br>7-20-01<br>7-23-01<br>7-25-01<br>7-30-01<br>8-24-01<br>10-8-01<br>10-10-01<br>10-15-01<br>10-17-01 | 97250 | $43.00 | $0.00 | F<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>F<br>N<br>N<br>N<br>N<br>N | $43.00 | CPT code description | Myofascial Release - documentation supports service billed. Reimbursement of 14 X $43.00 = $602.00 is recommended. |
| 7-23-01<br>7-25-01<br>8-24-01<br>10-5-01<br>10-8-01<br>10-10-01<br>10-15-01<br>10-17-01 | 97265 | $43.00 | $0.00 | N | $43.00 | CPT code description | Joint mobilization - Documentation supports service billed. Reimbursement of 8 X $43.00 = $344.00 is recommended. |

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|---|---|---|---|---|---|---|---|
| 7-27-01<br>8-1-01<br>10-1-01<br>10-3-01<br>10-24-01 | 97250 | $43.00 | $0.00 | No EOB | $43.00 | CPT code description | Myofascial Release - documentation supports service billed. Reimbursement of 5 X $43.00 = $215.00 is recommended. |
| 7-27-01<br>8-1-01 | 97032 | $22.00 | $0.00 | No EOB | $22.00 | CPT code description | Electrical Stimulation Documentation supports service billed. Reimbursement of 2X $22.00 = $44.00 is recommended. |
| 9-28-01<br>10-19-01 | 97265 | $43.00 | $0.00 | A | $43.00 | CPT code description Rule 134.600 | Preauthorization approval was obtained on 8-30-01 and 11-2-01 for 4 weeks of physical therapy. Therefore, date of service 9-28-01 was pre-authorized Reimbursement of $43.00 is recommended.<br><br>Date of service 10-19-01 was not preauthorized; therefore, no reimbursement is recommended. |
| 9-28-01<br>10-19-01<br>10-22-01 | 97250 | $43.00 | $0.00 | A | $43.00 | CPT code description | Preauthorization approval was obtained on 8-30-01 and 11-2-01 for 4 weeks of physical therapy. Therefore, date of service 9-28-01 was preauthorized Reimbursement of $43.00 is recommended.<br><br>Dates of service 10-19-01 and 10-22-01 were not preauthorized; therefore, no reimbursement is recommended. |
| 10-1-01<br>10-3-01<br>10-24-01 | 97265 | $43.00 | $0.00 | No EOB | $43.00 | CPT code description | Joint mobilization - Documentation supports service billed. Reimbursement of 3 X $43.00 = $129.00 is recommended. |
| 10-19-01<br>10-22-01<br>10-24-01 | 97110 | $140.00<br>$105.00<br>$105.00 | $0.00 | A | $35.00. / 15 min | Rule 134.600(h) | Preauthorization was not obtained for these dates of service; therefore, no reimbursement is recommended. |
| 10-19-01<br>10-22-01<br>10-24-01 | 97035 | $22.00 | $0.00 | A | $22.00 | Rule 134.600(h) | |

| TOTAL | | | The requestor is entitled to reimbursement of **$2691.00.** |
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This Decision is hereby issued this 5th day ofAugust 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay $2691.00 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 to dates of service 09/21/01 through 06/21/02 in this dispute.

This Order is hereby issued this 6th day of August 2003.

Roy Lewis
Medical Dispute Resolution Supervisor
Medical Review Division

June 13, 2003

MDR #: M5-04-2778-01
IRO Certificate No.: 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

**Clinical History:**
This male claimant injured his left knee in a work-related accident on ___. He received conservative care, and had surgery on 09/12/01 for a tear of the medial meniscus.

**Disputed Services:**
Office visits, myofascial release, joint mobilization, electric muscle stimulation, ultrasound, and other chiropractic treatments from 06/20/01 through 12/19/01.

**Decision:**
The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that none of the services in question were medically necessary in this case.

**Rationale:**
No documentation was provided describing or outlining a specific pre-surgical treatment plan with specific goals based on specific exam findings. For example, although there was an ROM of the left knee deficit, no specific treatment or application of the treatment was described, and the expected outcome. Although ROM was generally quantified in the initial exam, patient response to treatment and improvement of ROM was not described in post-treatment documentation by qualitative and quantitative measures. Only general terms were used in the doctor's exam under "treatment plan". Such documentation is not descriptive of specific application and the basis or rationale for its use, specifically on a medial meniscus tear of the left knee. No physical assessment or orthopedic checks were re-evaluated post-treatment to determine if the patient's response warrants the same, additional, or ongoing treatment. Specific treatment, and its application to a specific muscle joint, or other injured tissue, was not described, which did not support the application of modalities used in the treatment of a torn meniscus.

A consulting M.D. noted on 07/26/01 that the injury is not responding to treatment and will not heal, and will require surgery. Therefore, chiropractic treatment after this point was not justified by the treating doctor.

Post-op rehabilitation 09/12/01 did not include a baseline study, such as FCE or physical assessment results, to support the treatment recommended. Again, specific applications of treatment were not described by the treating doctor. Office visits were not documented noting brief exam findings, outcome assessment results, or decision making on treatment recommendations. This lack of documentation does not support the medical necessity of the treatment in question from 06/20 through 12/19/01.