

MDR Tracking Number: M5-02-2917-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visit treatment/service were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that office visit treatment/service fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 7/9/0 to 11/8/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 24<sup>th</sup> day of June 2003.

Carol R. Lawrence  
Medical Dispute Resolution Officer  
Medical Review Division

CRL/crl

June 16, 2003

MDR Tracking #: M5-02-2917-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

\_\_\_ suffered a work injury on \_\_\_ when she tripped over a dolly and fell forward. She presented for evaluation on 3/26/01, was given exercises, heat and electrical muscle stimulation and a prescription for Celebrex. She experienced increased low back pain the next day. She presented to \_\_\_ on 3/30/01 with complaints of low back and gluteal pain, bilateral heel pain and a throbbing sensation when standing. A diagnosis of lumbar sprain/strain with myospasm was rendered with a treatment plan of passive care progressing to range of motion and strengthening exercises. \_\_\_ was taken off work.

#### DISPUTED SERVICES

Under dispute is the medical necessity of office visits provided from 7/9/01 through 11/8/01.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

For E/M procedures of established patients, two of the three components (history, examination and medical decision making) must be met or exceeded for a particular level of E/M service.

At the level of 99213: presenting problem is low to moderate; the history is expanded; the examination is also expanded and the decision-making is low. The office visit notes provided do not meet the criteria for at least two of the criteria.

Merely checking a series of boxes is inadequate with regards to communicating objective findings and meeting the requirement of an expanded examination: In which planes was motion restricted and to what degree producing what kind of symptoms; what muscles were in "spasm"; weakness of what muscles producing what symptoms, and to what degree?

On 8/7/01, bilateral low lumbar paraspasm (L>R) left sided tenderness is not an expanded examination. Nor is decreased spasms bl gluteal/lumbar pain on 10/1/01 or decreased spasms bl lumbar/gluteal musculature on 10/19/01.

There was no quantifying of the intensity of the patient's symptoms. It was impossible to tell from the daily notes if there was any change in the intensity of the symptoms from 7/9/01 through 11/8/01. The word "mildly" was used only one occasion (10/12/01 Subj Complaints) to quantify this patient's symptoms. This documentation does not meet the requirement of an expanded history.

There was no evidence of any decision-making having occurred. "Pt. tolerating tx. well" is an observation, not a decision. On only one occasion did anyone bother to circle "improved" (10/30/01). There was never a Rehab. Assessment made.

The documentation provided does not support the level of service for 99213 office visits.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy

As an officer of \_\_\_, dba \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,