

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-04-4750.M5**

MDR Tracking Number: M5-04-0138-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General 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 09-10-03.

The IRO reviewed office visits, range of motion measurements, joint mobilization, myofascial release, therapeutic exercises, manual traction, and physical performance test rendered from 06-03-03 through 07-11-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for:

- Office visits on 06-12-03, 06-13-03, 06-26-03, 07-01-03, 07-02-03, 07-08-03, 07-09-03 and 07-10-03
- Therapeutic exercises on 06-24-03, 06-26-03, 07-01-03, 07-08-03, and 07-10-03
- Joint mobilization, myofascial release, manual traction, on 07-01-03, 07-08-03 and 07-10-03
- Physical performance test on 07-03-03
- Myofascial release on 07-02-03, 07-07-03 and 07-09-03

On this basis, the total amount recommended for reimbursement (\$963.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity for:

- Office visits on 06-25-03 and 07-07-03,
- Therapeutic exercises on 06-09-03, 06-23-03, 06-25-03, 07-02-03, 07-07-03, and 07-09-03,
- Joint mobilization and manual traction on 07-02-03, 07-07-03, and 07-09-03
- Range of motion measurements on 06-18-03 and 07-08-03.

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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

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

On 11-29-03, 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. Relevant information was not submitted by the requestor in accordance with Rule 133.309 (g)(3) in support of the fee component in this dispute. Therefore reimbursement is not recommended.

This Decision is hereby issued this 3<sup>rd</sup> day of March 2004.

Georgina Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

### **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 Decision is applicable for dates of service 06-18-03 through 07-09-03 in this dispute.

This Order is hereby issued this 3<sup>rd</sup> day of March 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

### **NOTICE OF INDEPENDENT REVIEW DECISION- AMEND**

**Date:** March 1, 2003

**RE: MDR Tracking #:** M5-04-0138-01  
**IRO Certificate #:** 5242

\_\_\_\_\_ 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 proposed 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 Chiropractor who has a temporary ADL exemption. The Chiropractor 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**

It appears the claimant reportedly slipped and fell backwards striking his head on a brick wall while he was trying to empty or work with trash cans on \_\_\_\_\_. There was no reported loss of consciousness; however, the claimant reported headaches, blurred vision, nausea and complained of pains mostly in his neck, head, mid-back, low back and right elbow. The overall chiropractic documentation appears to mention very little about the claimant's lumbar spine, however. The claimant was seeing \_\_\_\_\_ for neurological follow ups and examinations. The claimant has also undergone a brain MRI which was essentially normal for injury related pathology.

The claimant has also undergone a right elbow MRI which allegedly revealed mild olecranon bursitis as well as mild lateral epicondylitis. An MRI of the cervical spine revealed multiple noncompressive disc protrusions at 3 levels from C4 through C7. There were also degenerative joint changes contributing to what was felt to be some mild bilateral foraminal narrowing at the C5/6 level. The overall documentation continued to suggest the claimant remained neurologically intact. I believe it was mentioned in a designated doctor exam report that the electrodiagnostic findings were normal. The designated doctor did find the claimant to be at maximum medical improvement as of 7/21/03 with 9% whole body impairment rating; however, this date of maximum medical improvement falls after the disputed dates of service. Multiple range of motion and strength tests from June through August 2003 were reviewed. Multiple daily chiropractic notes were also reviewed.

### **Requested Service(s)**

The medical necessity of the outpatient services including office visits, range of motion measurements, joint mobilization, myofascial release and therapeutic exercises, manual traction, and physical and performance testing, which were performed from 6/3/03 through 7/11/03 as laid out in the table of disputed services.

### **Decision**

I agree with the insurance carrier and find that some of the disputed services were not reasonable or medically necessary. However, many of the disputed services from 6/3/03 through 7/11/03 were, in my opinion, medically necessary as summarized below in the rationale.

Medically necessary: CPT 99213, dated 6/25/03 and 7/7/03  
CPT 97110, dated 6/9/03, 6/23/03, 6/25/03, 7/2/03, 7/7/03, 7/9/03  
CPT 97625, dated 7/2/03, 7/7/03, 7/9/03  
CPT 97122, dated 7/2/03, 7/7/03, 7/9/03  
CPT 95851, dated 6/18/03, 7/8/03

Not medically necessary: 6/12/03 (99213); 6/13/03 (99213); 6/24/03 (97110); 6/26/03 (99213, 97110); 7/1/03 (99213, 97265, 97250, 97122, 97110); 7/2/03 (99213, 97250); 7/3/03 (97750); 7/7/03 (97250); 7/8/03 (99213, 97265, 97250, 97122, 97110); 7/9/03 (99213, 97250); 7/10/03 (99213, 97265, 97250, 97122, 97110)

**Rationale/Basis for Decision**

It appears that the insurance carrier paid medically necessary services through at least 6/17/03. Routine evaluation of range of motion and strength would be considered medically necessary and reasonable to document progress. It is also my opinion that the office visits were not reasonable or medically necessary except for at once per week through the disputed time frame. There is no reason to bill an office visit on every single visit while the claimant is undergoing a physical therapy program. Therefore, it is my overall opinion that office visits at once per week during the weeks of 6/2/03, 6/9/03, 6/16/03, 6/23/03, and 7/7/03 were reasonable and medically necessary for monitoring purposes at once per week only. If the carrier has paid one office visit during these weeks of 6/2/03 through 7/7/03, then that would be sufficient. This particular decision was difficult because some of the services were paid and the claimant was found to be at MMI after the dates of service. There was sufficient progression shown, in my opinion, when reviewing the range of motion and strength evaluations throughout the documentation. Most of the improvement occurred from 6/3/03 through 7/8/03. There were fairly large increases in range of motion in the cervical spine as well as overall strength and grip strength. This in my opinion justified a majority of the treatment during the disputed dates of service. It is my opinion that all active care billed at 97110, joint mobilization billed at 97265 and manual traction billed at 97122 were reasonable and medically necessary for the nature of the injury and given that progress was shown during this time frame.

It is my opinion, however, that the daily care which was rendered, particularly during the week of 6/23/03, as well as on 7/7/03, was not reasonable or medically necessary. Daily treatment at over 8 weeks post injury is not medically necessary unless a work hardening program or chronic pain management program is occurring. Therefore, it is my opinion that the active services including the 97110 code, the 97265 code and the 97122 codes which were billed during the weeks of 6/23/03, and 7/7/03 were only reasonable and medically necessary at 3 times per week, non-consecutive days. Going back for a moment, the office visits billed on 6/9/03, 6/12/03 and 6/13/03 were not entirely reasonable and medically necessary; however, please refer to the above mentioned discussion regarding the frequency of what the office visits should be. All myofascial release which was billed at the 97250 code was not reasonable or medically necessary in my opinion as this was passive in nature and not medically necessary at 7 weeks post injury and beyond.

In Accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this \_\_\_ day of \_\_\_ 2004.

Signature of IRO Employee:

Printed Name of IRO Employee: