

MDR Tracking Number: M5-04-0592-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-27-03.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The myofascial release and joint mobilization for dates of service 02-24-03 through 03-24-03, the electric stimulation and ultrasound therapy for dates of service 02-24-03 through 03-7-03 and the therapeutic exercises and therapeutic procedures for dates of service 02-24-03 through 04-7-03 were found to be medically necessary. The myofascial release and joint mobilization for dates of service 03-26-03 through 06-06-03, the electric stimulation and ultrasound therapy for dates of service 03-17-03 through 06-06-03, the therapeutic exercises and therapeutic procedures for dates of service 04-09-03 through 06-06-03, office visits and copies of reports were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for office visits, electrical stimulation, ultrasound therapy, joint mobilization, myofascial release, therapeutic procedures, therapeutic exercises, copies of reports.

This Findings and Decision is hereby issued this 12<sup>th</sup> day of January 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 to dates of service 02-24-03 through 04-07-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 12<sup>th</sup> day of January 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division  
RL/dlh

January 7, 2004

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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

\_\_\_, a 59-year-old female, sustained an on the job injury to her right knee while working as a custodian for \_\_\_\_. She was mopping stairs when she wrenched and twisted her right knee. She had immediate right knee pain and stiffness, which worsened over the following weekend, so she presented to the company doctor. She was x-rayed and sent for some physical therapy. This apparently "aggravated her condition", so she was referred to \_\_\_\_, an orthopedist who ordered a MRI. This was performed on 08/27/03 and revealed a grade 3 medial meniscus tear, degenerative arthritis primarily involving the medial and patellofemoral compartment, with evidence of grade 2/grade 3 chondromalacia patella. Surgical intervention was recommended, however an initial date in October 2002 was postponed due to questions over cardiac clearance. The patient meanwhile changed treating providers to \_\_\_ a chiropractor on 9/35/02 and underwent a conservative care program with some improvement. She eventually progressed to surgery on 02/21/03. Surgery consisted of right knee arthroscopy with medial meniscus debridement and chondroplasty of the medial tibial plateau. The patient then underwent postoperative rehabilitation with exercises and adjunctive therapeutic modalities with \_\_\_\_.

In reviewing the documentation, there are numerous preprinted "superbill-type" documents outlining procedures performed. Although each has a hand written notation indicating that the patient complains of "right knee soreness / aching", with a circling of an "ache" pain descriptor on each, it is unsure if this is meant to be either a billing document or an office visit note. No examination findings are mentioned and there is no assessment / diagnostic impression noted, both of which are needed to qualify it as the latter. This documentation remains essentially unchanged throughout the whole of the patient's course of care. In addition, there are some "active rehabilitation exercises" worksheets with a list of 10 exercises and the time spent performing each exercise. There does not appear to be any change in the exercises administered, either in terms of exercise type, progression, time or repetitions. As such, the supplied documentation is repetitious, contains minimally clinically useful information and does not show significant progress / substantive change in treatment. Unfortunately this provides precious little clinical insight as to the patient's status, progression or improvement / response to care.

Additionally there are two dictated office notes dated 3/11/03 and 5/27/03 along with sequential range of motion and muscle testing reports. These services do not appear to be part of the disputed services in terms of re-imburement. The ROM/strength reports do indicate some improvement in the patient's function.

#### REQUESTED SERVICE (S)

Office visits, electrical stimulation (unattended), ultrasound therapy, joint mobilization, myofascial release, therapeutic procedures, therapeutic exercises, copies of reports, office visits for established patient for dates of service 2/24/03 through 6/6/03.

#### DECISION

In answer to the question of medical necessity for office visits in conjunction with the patient's treatment program, there is medical necessity established for only some of the services rendered.

- Documentation fails to support the level of service billed for an expanded (99213) evaluation and management service / office visit anywhere in the supplied documentation.
- There is also failure to find any established requirement or documentation supporting the need for 99212 to be billed on each patient encounter through the patient's therapy program.
- Concerning codes 97250 and 97265 (myofascial release and joint mobilization): these procedures are medically necessary through the time period 02/24/04 through 3/24/03 only.
- Concerning codes 97014 and 97035 (electrical muscle stimulation and ultrasound): there is establishment of medical necessity for these modalities as employed in conjunction with the other therapeutic procedures between the 02/24/03 and 03/07/03 time period.
- Concerning code's 97110 and 97150 (therapeutic exercises and group therapeutic procedures): these services are medically necessary though 04/07/03 only.
- There is no establishment of medical necessity for any other procedures beyond the 04/07/03 timeframe.

- Concerning the billing of 99080 code: unfortunately there is no information as to what copies were made and why these charges were billed. Therefore, there is no comment on the "medical necessity" of these charges.

#### RATIONALE/BASIS FOR DECISION

The patient was essentially on a focused post-operative rehabilitation/strengthening program for the right knee, which, according to the documentation, was progressing on an undeviating course. Concerning the office visits, the patient was on a relatively straight-forward post-surgical rehabilitation program, which appeared to be progressing on a more or less undeviating course. Documentation fails to establish the necessity for an expanded level of evaluation and management service each week. The documentation does not support such level of service on any of the billed encounter dates.

There was no evidence in the documentation suggesting the requirement for additional office visits beyond a basic monitoring every two weeks. Unfortunately, the supplied documentation fails to document progression / response / deviation to the program to support continuing care beyond a standard six week course.

CPT code 99213 (office or outpatient visit), requires two of three key components: an expanded problem focused history; an expanded problem focused examination; or medical decision-making of low complexity). There was no documentation supporting this level of service and provided in the reviewed materials.

99212 (office or outpatient visit for the evaluation and management of an established patients, requires at least two of three key components: a problem focused history; a problem focused examination; straightforward medical decision-making making).

97014 and 97035: These seem to be acceptable procedures performed in a postoperative setting and in conjunction with the initiation / transition to an active therapy program for the type of injury sustained by this patient. Beyond 3/24/03, mobilization and soft-tissue work procedures would be somewhat redundant and duplicative when performed in conjunction with the types of therapeutic exercises employed (as outlined in the documentation).

A six week course of post-operative rehabilitation, to include passive physiotherapeutic modalities in conjunction with some manual therapy and a three week course of exercises should be sufficient to discharge this patient to a home exercise program. As mentioned, there did not appear to be any type of progression or change in the types of active exercises employed in this case. The exercises were identical and time frames for performing these exercises were also identical. The exercises employed are not sophisticated. Considering the lack of deviation or progression, a three-week course of these exercises should be ample to allow for discharge to a home environment with the patient continuing to perform these on her own. Although there is some improvement indicated on the range of motion/muscle strength reports, this could well have been attained with some basic compliance by performing these exercises in a home environment.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.