

MDR Tracking Number: M5-04-1271-01

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 1-9-04.

The IRO reviewed office visits and physical therapy treatment rendered from 9-9-03 through 10-31-03 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. 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.

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 April 21, 2004, 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 | MARS (Maximum Allowable Reimbursement) | Reference | Rationale |
|---------|----------|---------|---------|-----------------|--|-----------------------|-------------------------------|
| 9-23-03 | 99211 | \$26.94 | \$11.26 | F | \$18.00 | Paid check # 09066399 | Not in dispute, service paid. |
| 11-7-03 | 99211 | \$26.94 | \$11.26 | R | \$18.00 | Email from | |

IV. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is not** entitled to reimbursement for CPT codes 99213, 97530, 97110, 97110, 95831, 99211, and 99212.

The above Findings and Decision are hereby issued this 13th day of August 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

March 31, 2004

Re: IRO Case # M5-04-1271
IRO Certificate #4599

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient injured her right hand on ___ when a heat seal machine came down on the hand. She was diagnosed with a second degree burn of the right hand. She sought chiropractic treatment. She was treated by her chiropractor, and also was later treated with injections by an M.D.

Requested Service(s)

99213 OV, 97530 Ther Act, 97110 Ther Eexer, 95831 Muscle Test, 97250 Myofascial Reeducation 9/9/03-10/31/03

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

Based on the records provided for this review, the patient had had an extensive trial of conservative treatment prior to the dates in dispute without documented relief of symptoms or improved function. As of 12/8/03 her VAS was still 7/10. This was after over five months of conservative treatment. The documentation provided does not support use of code 97530, as it was excessive and failed to be beneficial to the patient. Code 97110 was over utilized, and one on one therapeutic exercises were not necessary. A home-based exercise program would have been appropriate. The documentation provided also failed to support the need for myofascial reeducation or muscle testing. Three months of intensive chiropractic treatment had failed to be beneficial, and the records do not support the need for continued use of failed conservative modalities. The treatment appears from the records to be iatrogenic in that the patient's subjective complaints were more intense, and her objective findings supporting these complaints more numerous the longer treatment was continued. The records provided do not show how the disputed services were medically necessary.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.