

MDR Tracking Number: M5-04-1517-01

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 January 26, 2004.

The IRO reviewed office visits, joint mobilization, aqua therapy, massage therapy, electric stimulation, hot/cold pack therapy, myofascial release and medical conference by physician for dates of service 02/20/03 through 05/09/03 that was denied based upon "V".

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.

The services rendered from 02/20/03 through 03/20/03 including EMS, ice, aquatic therapy, office visits dated 03/26/03 and 04/25/03 **were** found to be medically necessary. The remainder of the services performed, from 02/20/03 through 05/09/03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for office visits, joint mobilization, aqua therapy, massage therapy, electric stimulation, hot/cold pack therapy, myofascial release and medical conference by physician.

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.

On April 29, 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.

- CPT Code 99213 for dates of service 02/25/03, 02/27/03, and 03/07/03. Neither party submitted EOBs; therefore, these dates of service will be reviewed according to the 1996 Medical Fee Guideline. The requestor submitted convincing evidence of carrier receipt of the provider's requestor for EOBs in accordance with Rule 133.307(e)(2)(B). Per the 1996 Medical Fee Guideline, E&M Ground Rule (VI)(B) reimbursement in the amount of \$144.00 (\$48.00 x 3) is recommended.
- CPT Code 97265 for dates of service 02/25/03 and 06/30/03. Neither party submitted EOBs; therefore, these dates of service will be reviewed according to the 1996 Medical Fee Guideline. The requestor submitted convincing evidence of carrier receipt of the provider's requestor for EOBs in accordance with Rule 133.307(e)(2)(B). Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(C)(3) reimbursement in the amount of \$86.00 (\$43.00 x 2) is recommended.
- CPT Code 97032 (10 units total) for dates of service 02/25/03, 02/27/03 and 03/27/03. Neither party submitted EOBs; therefore, these dates of service will be reviewed according to the 1996 Medical Fee Guideline. The requestor submitted convincing evidence of carrier receipt of the provider's requestor for EOBs in accordance with Rule 133.307(e)(2)(B). Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(10)(a) reimbursement in the amount of \$220.00 (\$22.00 x 10) is recommended.
- CPT Code 97010 (6 units total) for dates of service 02/25/03, 02/27/03 and 03/27/03. Neither party submitted EOBs; therefore, these dates of service will be reviewed according to the 1996 Medical Fee Guideline. The requestor submitted convincing evidence of carrier receipt of the provider's requestor for EOBs in accordance with Rule 133.307(e)(2)(B). Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(10)(a) reimbursement in the amount of \$110.00 (\$11.00 x 10) is recommended.

- CPT Code 99080-73 for dates of service 03/12/03 and 04/10/03 denied as "V". Per Rule 129.5 the Work Status Report is a Commission required report which MDR has jurisdiction. Per Rule 133.106(f)(1) reimbursement in the amount of \$30.00 (\$15.00 x 2) is recommended.

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 outlined above as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- 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 02/20/03 through 05/09/03 as outlined above 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 10th day of November 2004

Marguerite Foster
 Medical Dispute Resolution Officer
 Medical Review Division

MF/mf
 Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 26, 2004

RE:

MDR Tracking #: M5-04-1517-01 Amended Decision
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 Chiropractic physician reviewer who has an ADL certification. The reviewer 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

According to the supplied documentation, it appears that the claimant injured his low back and right knee while performing practice drills for his job on _____. A MRI on 05/11/2002 revealed a parrot beak tear of the right medial meniscus. A second MRI was performed on 06/15/2002 that revealed a 1-2 mm disc bulge at L4-5 and a 2 mm posterior central herniation at L5-S1. On The claimant underwent arthroscopic surgery on 02/12/2003 with _____ Chiropractic therapy sessions were rendered between 02/20/2003 – 05/09/2003. A statement letter from _____ was reviewed. The documentation ends here.

Requested Service(s)

Please review and address the medical necessity of the outpatient services including joint mobilization, office visits, aqua therapy, massage therapy, conference by physician, electrical stimulation (EMS), hot/cold packs, myofascial release rendered between 02/20/2003 and 05/09/2003.

Decision

I agree with the treating doctor that the services rendered from 02/20/2003 – 03/20/2003 including EMS, ice, special reports, aquatic therapy, office visits dated 03/26/2003 and 04/25/2003 were medically necessary. I agree with the insurance company and disagree with the treating doctor that the remainder of the services performed from 02/20/2003-05/09/2003 were not medically necessary.

Rationale/Basis for Decision

After the surgery was completed and the claimant was allowed to begin post-surgical rehabilitation, it would be reasonable for the claimant to undergo 4 weeks of active therapy. The aquatic therapy, electrical muscle stimulation, ice therapy and special reports were within current medical guidelines and is considered medically necessary. The office visits, massage and manipulation are not considered reasonable in the rehabilitation of the claimant's condition. Office visits occurring more frequently than monthly were not objectively documented and are not considered reasonable for the continued management of the patient's ongoing care. Monthly office visits are medically warranted for the continued reporting of progression in the claimant's condition as well as any necessary referrals. Therapy should have continued after the initial 4 weeks with a proper home-based exercise program that would continue to improve the range of motion, increase strength, improve return to work with normal activities of daily living while decreasing chances of doctor dependence. The continued doctor supervised treatment beyond the first 4 weeks is not considered medically necessary. The documentation supports the claimant had a sufficient amount of supervised therapy prior to his surgery to understand what continued activities would help improve his range of motion and decrease his pain at home.