

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

SOAH DOCKET NO. 453-05-1647.M5

MDR Tracking Number: M5-04-1587-01

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, 133.307 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 02-02-04.

The IRO reviewed therapeutic procedure, PHYS TX 1 AR unlisted procedure, joint mobilization, Phys TX AR Traction, established office visits/evaluation, unlisted procedure nervous, prolonged service office, physical medicine treatment-1 area, manipulation cervical, manual therapy and chiropractic manipulation rendered from 02-01-03 through 12-15-03 that were denied based upon "V".

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 06-03-04, 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 99080-73 for dates of service 02-10-03, 02-28-03, 03-15-03, 03-29-03 and 04-12-03 denied with denial code V. This service is a TWCC required report and will therefore be reviewed as a fee issue. The requestor submitted relevant information to support delivery of service for dates of service 02-28-03, 03-15-03, 03-29-03 and 04-12-03 but did not submit relevant information for date of service 02-10-03. Reimbursement is recommended in the amount of \$60.00 (\$15.00 X 4). No reimbursement is recommended for date of service 02-10-03.

The requestor nor respondent submitted an explanation of benefits for CPT code 99455-V5WP on date of service 04-22-03. Review of the reconsideration HCFA reflected proof of submission. The service is reviewed according to the 96 Medical Fee Guideline. Reimbursement is recommended in the amount of \$435.00 per 96 Medical Fee Guideline E/M GR XXII(D)(1)(a).

The requestor nor respondent submitted an explanation of benefits for CPT codes 98940 and 97140-59 on date of service 12-15-03. Review of the reconsideration HCFA reflected proof of submission. The services are reviewed per the Medical Fee Guideline effective 08-01-03. Reimbursement is recommended in the amount of \$31.68 for CPT code 98940 and \$65.10 for CPT code 97140-59.

Total reimbursement for the fee issues is recommended in the amount of \$591.78.

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 02-28-03, 03-15-03, 03-29-03, 04-12-03, 04-22-03 and 12-15-03 in this dispute.

This Findings and Decision and Order are hereby issued this 5th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

May 13, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Corrected services in dispute.

Re: Medical Dispute Resolution
MDR #: M5-04-1587-01
IRO Certificate No.: IRO 5055

Dear ____:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine who is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's
H&P/Neurological Exam 02/12/03, S.O.A.P. Notes – 11/25/02, 02/04/03 thru 12/15/03
Impairment Exams – 12/04/02, 01/08/03, 04/22/03
Lumbar epidural steroid injections – 03/12, 04/08, 05/08 2003
Lumbar MRI 12/04/02, X-ray 11/07/02, Lumbar CT 03/07/03

Clinical History:

Patient received extensive physical medicine treatments and lumbar injections after injuring lumbar spine at work on 09/26/02.

Disputed Services:

Therapeutic procedure, Phys TX 1 AR unlisted procedure, joint mobilization, Phys TX AR Traction, EST OFF/OTH O/P VST/EVL, Analysis Computer Data, Phys TX 1 AR Traction, Prolonged Service, Unlisted Procedure Nervouse, Prolonged Service Office, Phys Med Trtmt-1area, Manipulation Cervical, Manual Therapy, and Chiropractic Manipulation during the period of 02/01/03 through 12/15/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

On November 25, 2002, the treating doctor recommended treatment 3 times per week for 8 weeks. Based on the history and examination of the patient, it would not be unreasonable to conclude that care would be indicated for that time frame.

However, the medical records submitted provide no documentation to support care after that initial 8-week period. In the month of February 2003, “no change” in the patient’s condition or symptoms was noted in the daily chart notes...63 separate times. That documentation clearly indicates that this care was medically unnecessary on the basis that the patient obtained no relief from the treatments, promotion of recovery was not accomplished and there was no enhancement of the employee’s ability to return to or retain employment.

From DOS to DOS and from month to month, the notes were “canned,” computer generated responses and were essentially super imposable on each other. Therefore, no basis, documentation or support was submitted that would support the medical necessity of the care.

When the treating doctor did offer new information about the patient’s response to care, it documented that the care was ineffective. Specifically, the examination performed on 02/03/03, at the beginning of the specified care, indicated that lumbar extension was 30 degrees, left lateral bending 35 degrees and right lateral bending was 35 degrees. Yet on the impairment rating examination performed on 04/22/03, lumbar extension had decreased 6 degrees, left lateral bending had decreased 5 degrees and right lateral bending had decreased 8 degrees.

The medical records submitted indicate that the treating doctor from DOS to DOS and from month to month repeatedly manipulated “the left ilium (PIIN) and L1 (PRI-M)” even though there was no improvement. More importantly, diagnostic imaging had previously confirmed that the patient’s primary problem was located at the L-5 S-1 level. It is noteworthy to mention that L-5 S-1 was the location of the beneficial epidural injections. The manipulative treatment was not focused at the problem area.

Sincerely,