

MDR Tracking Number: M5-04-1671-01

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.

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 2/09/04, therefore the following date of service is not timely: 2/7/03.

The following disputed services were withdrawn by the requestor on April 12, 2004 and therefore will not be considered in this review:

CPT codes 95900, 95904 and 95935 for date of service 3/10/03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460** for the paid IRO fee. 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.

The IRO has determined that the office visits, massage therapy, neuromuscular re-education, electrical stimulation, and ultrasound services rendered from 2/10/03 through 2/26/03 and the office visits on 3/26/03, 5/1/03, 5/29/03, 6/27/03, 8/5/03, 8/20/03, 9/25/03 **were** medically necessary.

The following services and dates of service **were not** medically necessary:

- CPT code 95925 on 3/10/03
- CPT code 95999 on 3/10/03
- CPT code 99211 on 3/12/03 and 8/25/03
- CPT code 99212 on 4/17/03, 7/7/03
- CPT code 99213 on 3/19/03, 3/28/03, 4/4/03, and 8/13/03
- CPT code 99358 on 4/4/03, 4/17/03, 5/1/03, 6/27/03, 7/7/03, and 8/20/03
- CPT code 99241 on 4/11/03
- CPT code A4558 on 4/11/03
- CPT code 95860 on 4/11/03
- CPT code A4556 on 4/11/03

The respondent raised no other reasons for denying reimbursement for the above listed services.

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 May 24, 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 99080-73** for date of service 8/20/03: The carrier denied CPT Code 99080-73 with a U for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter therefore **reimbursement is recommended** in the amount of \$15.

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;
- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b);
- 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 2/10/03 through 9/25/03 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 Decision and Order is hereby issued this 7<sup>th</sup> day of October 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc

May 10, 2004

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

Re: Medical Dispute Resolution  
MDR #: M5-04-1671-01  
IRO Certificate No.: 5055

Dear Ms. Lopez:

\_\_\_ 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 and who is currently on the TWCC Approved Doctor List.

### **REVIEWER'S REPORT**

#### **Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's  
Peer reviews and treating doctor's correspondence: 03/03 – 03/04.  
Orthopedic consultation 03/28/03.  
S.O.A.P. notes: 02/07/03 – 10/21/03.  
Nerve conduction study 03/10/03.

#### **Clinical History:**

The claimant was injured at work on \_\_\_\_. He initially began a regime of rehab, which was performed between October 2002 and December 2002. All other details of his injury and treatment protocol prior to February 10, 2003 are unknown due to the lack of documentation provided.

#### **Disputed Services:**

Office visits, massage therapy, neuromuscular re-education, electrical stimulation, ultrasound therapy, office consults, somatosensory techniques, neuro-protocol (PRO), conduction gel, and muscle testing during the period of 02/10/03 through 09/25/03.

**Decision:**

The reviewer partially agrees with the determination of the insurance carrier as follows:

1. All services provided between February 10, 2003 through February 26, 2003 were reasonable and necessary for treatment of exacerbation of the claimant's condition. I base this on the guidelines recommended by The Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters, chapter 8, entitled, *Duration of Care For Uncomplicated and Complicated Cases*. This exacerbation should be treated as an acute case until the patient's response or condition should reflect one of a complicated nature, as this case did.
2. EMG on March 10, 2003 was a reasonable and necessary diagnostic study for a patient with the claimant's history and diagnosis.
3. The dates of service March 26<sup>th</sup>, May 1<sup>st</sup>, May 29<sup>th</sup>, June 27<sup>th</sup>, August 5<sup>th</sup>, August 20<sup>th</sup>, and September 25<sup>th</sup> of 2003 were reasonable and necessary based on the 1 visit per month treatment protocol. These dates are enough to allow the doctor to review his findings with the patient, remain abreast of his condition, and to make recommendations.
4. The dates of service March 19<sup>th</sup>, March 28<sup>th</sup>, April 4<sup>th</sup>, April 17<sup>th</sup>, July 7<sup>th</sup>, August 13<sup>th</sup>, August 25<sup>th</sup>, and September 2<sup>nd</sup> do not appear to have been reasonable and necessary based on the treatment notes. Any report of findings done on these dates could have been performed on the monthly visit.
5. The diagnostic study performed on April 11, 2003 is not verified by any accompanying documentation for the necessity, but was actually performed; therefore, it cannot be deemed reasonable and necessary.

**Rationale:**

Based on the documents provided, it is not completely clear as to the reason the claimant began receiving his second round of rehab on February 4, 2003. It is deduced from the reports, and the daily SOAP notes that he evidently experienced exacerbation of his previous symptoms on or around February 4, 2003, and returned to his treating doctor for treatment.

The notes show he responded somewhat to the therapies between February 4<sup>th</sup> and February 17<sup>th</sup> after which time his symptoms increased in severity. At this point in the note, the subjective and objective statements do not coincide. The claimant reports that on February 17<sup>th</sup> his severity had increased, but the assessment on the note states that the claimant had a slight improvement in his condition, but then again the same is reported on February 21<sup>st</sup>. Then, on February 24<sup>th</sup> and 26<sup>th</sup> the patient states that there had been no changes in his condition, but the assessment states that the claimant's status has deteriorated. Finally on March 12<sup>th</sup>, the patient reports a reduction in severity, but the assessment states symptomatology had remained unchanged.

At this point the treating doctor recommends rehab stop, and the patient continue coming two times a month until re-examination. Then, on March 19<sup>th</sup>, just seven days later, he recommends treatment be one time a month until re-evaluation. The patient again receives treatment on March 26<sup>th</sup> and 28<sup>th</sup>. In the reviewer's opinion, there is no consistency to the treatment plan as recommended and what actually took place. The notes also show no significant reason that altering the treatment plan of one time a month was necessary. It is necessary for the treating doctor to remain current on the patient's condition and the interview reports with the patient, but one time a month is reasonable, unless otherwise documented for a change in his protocol. In this case, the

treating doctor repeatedly states that the treatment will be one or two times a month until re-examination, but no documentation has been provided that indicates a re-evaluation was ever performed to justify a change in the protocol.

Sincerely,