

MDR Tracking Number: M5-04-1686-01

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 02-10-04.

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 range of motion measurements on 9/29/03, 10/22/03, and 12/08/03; muscle testing on 10/07/03, 11/18/03, and 12/09/03; and office visits, therapeutic activities, and therapeutic exercises rendered from 9/29/03 through 12/10/03 **were** medically necessary. The range of motion measurements on 10/16/03; muscle testing on 10/21/03; and neuromuscular re-education and neurological/neuromuscular diagnostic procedures from 9/29/03 through 12/10/03 **were not** found to be medically necessary. 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 20, 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 95851 for date of service 11/17/03 was denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOBs, however, review of the reconsideration HCFA and the certified mail receipt reflected proof of submission in accordance with Rule 133.308 (f)(3). Therefore, the disputed service will be reviewed according to the Medicare Fee guidelines, and **reimbursement is recommended** in the amount of \$71.56 (for 2 units).

CPT code 99212 for date of service 12/02/03-review of the documentation in file reveals that per EOB on audit date 12/31/03, payment was recommended in the amount of \$47.23. However, the carrier did not submit documentation to reflect proof of payment. **Reimbursement is recommended** in the amount of \$47.23.

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 Medicare program reimbursement methodologies 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 9/29/03 through 12/09/03 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 Decision and Order is hereby issued this 2nd day of November 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

NOTICE OF INDEPENDENT REVIEW DECISION

April 29, 2004

Amended Letter 10/12/04

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: MDR Tracking #: M5-04-1686-01
 IRO Certificate #: IRO4326

The ___ 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 rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine in 1986 and provides

health care to injured workers. ___'s health care professional 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

This 36 year old male injured his back on ___ when he tripped when lifting a rack of trays while on the job. On 10/09/03, the MRI was suspicious for “5mm right paracentral disk herniations impinging the proximal right S1 nerve.” On 10/27/03, the lumbar studies showed, “no electrophysiological evidence of lumbar radiculopathy, lumbosacral plexopathy, or distal mononeuropathy” of the lower extremities. The treatment plan included steroids, therapeutic exercises and activities, and neuromuscular re-education.

Requested Service(s)

Range of motion (ROM) measurements, muscle testing, unlisted neurological or neuromuscular diagnostic procedure, office visits, neuromuscular re-education, therapeutic activities and therapeutic exercises from 09/29/03 through 12/10/03

Decision

It is determined that the ROM measurements on 09/29/03, 10/22/03, and 12/08/03 were medically necessary; however, the ROM measurements on 10/16/03 were not medically necessary. The muscle testing on 10/07/03, 11/18/03 and 12/09/03 was medically necessary; however, the muscle testing on 10/21/03 was not medically necessary. The office visits, the therapeutic activities and therapeutic exercises from 09/29/03 through 12/10/03 were medically necessary. The neuromuscular re-education and neurological or neuromuscular diagnostic procedure from 09/29/03 through 12/10/03 were not medically necessary.

Rationale/Basis for Decision

The patient was treated by a chiropractor and underwent muscle testing studies and ROM measurements. These studies are not necessary more than one time per month. Therefore, the muscle testing performed on 10/21/03 and the ROM measurements performed on 10/16/03 were not medically necessary.

The office visits, therapeutic activities and therapeutic exercises were medically necessary to treat this patient’s condition. The use of therapeutic exercises and activities are beneficial to proceed to the rehabilitation phase of care as rapidly as possible to minimize dependence on passive forms of treatment or care. This usually leads to the optimum result.

The use of neuromuscular re-education was not medically necessary because the neurological evaluations conducted of the course of the claimant’s care revealed no evidence of a neurological deficit. Neuromuscular reeducation is commonly utilized for post-stroke rehabilitation and is not commonly utilized for the management of conditions similar to the claimant’s conditions. Neuromuscular re-education is used to re-establish the neural link between the central nervous system and the motor system after neurological

injury. As there is no evidence of a neural injury noted, the use of the neuromuscular re-education is not consistent with the diagnoses.

The neuromuscular diagnostic procedure is limited in the ability to distinguish between anatomic sites of peripheral nerve injury. For example, it is not possible to distinguish between distal median nerve entrapment, proximal median nerve injury or cervical radiculopathy, since all may cause the same abnormality. Hence, the neuromuscular diagnostic procedure is not medically necessary.

Therefore, it is determined that the ROM measurements on 09/29/03, 10/22/03, and 12/08/03 were medically necessary; however, the ROM measurements on 10/16/03 were not medically necessary. The muscle testing on 10/07/03, 11/18/03 and 12/09/03 was medically necessary; however, the muscle testing on 10/21/03 was not medically necessary. The office visits, the therapeutic activities and therapeutic exercises from 09/29/03 through 12/10/03 were medically necessary. The neuromuscular re-education and neurological or neuromuscular diagnostic procedure from 09/29/03 through 12/10/03 were not medically necessary.

Sincerely,