

MDR Tracking Number: M5-04-1875-01

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. The dispute was received on 2-24-04.

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 \$650** 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 therapeutic procedures, muscle testing, office visits (except 5-30-03) and range of motion from 5-5-03 through 6-16-03 **were** found to be medically necessary. The myofascial release, massage, prolonged service on 5-27-03, 5-28-03 and 6-10-03, training in daily living activities on 5-28-03, and office visit on 5-30-03 **were not** found to be medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute 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 7-23-04 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.

The carrier denied CPT Code 99080-73 on 5-23-03 and 6-6-03, with a V for unnecessary medical treatment based on a peer review, 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 and, therefore, recommends reimbursement. Per 133.106(f)(1) **recommend reimbursement of CPT Code 99080-73 for \$30.00.**

CPT code 99455-L4 for date of service 6/23/03 was denied by the carrier with a V for unnecessary medical treatment based on a peer review, however, according to Rule 134.202 (6)(B)(iii), this exam is not subject to IRO review. The requestor billed the above service in accordance with Rule 134.202

(e)(6)(D)(II)(-b-)(1-2), the requestor submitted relevant information to support delivery of service, therefore, **reimbursement is recommended in the amount of \$381.00.**

Regarding CPT code 99213 for 4-30-03: No EOB's were provided by either the requestor or the carrier. However, there is "convincing evidence of the carrier's receipt of the provider's request for an EOB" according to 133.307 (e)(2)(B). **Recommend reimbursement of \$48.00.**

Regarding CPT code 97750-MT for 5-1-03: No EOB's were provided by either the requestor or the carrier. However, there is "convincing evidence of the carrier's receipt of the provider's request for an EOB" according to 133.307 (e)(2)(B). **Per 1996 MFG recommend reimbursement of \$86.00. (\$43.00 MAR x 2)**

Regarding CPT code 95851 for 4-10-03: No EOB's were provided by either the requestor or the carrier. However, there is "convincing evidence of the carrier's receipt of the provider's request for an EOB" according to 133.307 (e)(2)(B). **Per the 1996 MFG recommend reimbursement of \$36.00.**

Pursuant to 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) 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 Decision is applicable for dates of service 4-10-03 through 6-23-03 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 Findings and Decision and Order is hereby issued this 18th day of November, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division
DA/da

NOTICE OF INDEPENDENT REVIEW DECISION

June 26, 2004

**Re: IRO Case # M5-04-1875, amended 7/22/04, 8/13/04, 8/27/04, 10/25/04
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 physician who is Board Certified in Physical Medicine and Rehabilitation, 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:

Medical Information Reviewed

1. Table of disputed service 2/27/03 – 7/8/03
2. Explanation of benefits
3. Medical records review 6/12/03
4. RME 6/9/03
5. D.O. medical records 3/26/03, 4/16/03, 5/7/03
6. Electrodiagnostic report 4/1/03
7. Spinal ultrasound 4/1/03
8. ROM report 4/10/03, 5/1/03, 5/2/03, 6/3/03
9. Physical performance evaluation 4/25/03
10. CT scan reports right knee, right hip 5/13/03
11. PT evaluation 4/30/03
12. Muscle testing report 6/2/03
13. Physical therapy notes 4/30/03 – 6/10/03
14. D.C. records 3/18/03 – 6/5/03
15. Physical therapy re evaluation
16. X-rays 3/28/03

History

The patient is a 42-year-old female who injured her right leg when she was stepping down

from the steps of her bus on _____. She felt pain in her right leg, which caused her to fall. She began treatment with her treating D.C. on 3/18/04. No diagnosis was given in the initial evaluation. On a 4/25/03 physical performance evaluation the patient demonstrated a sedentary performance level. Her job reportedly requires a medium physical demand level. The patient started active physical therapy on 4/30/03, and this was continued until the patient was discharged from physical therapy on 6/10/03.

Requested Service(s)

Therap Proc., myofascial release, office outpatient visit, prolonged service, activities, muscle testing, range of motion, massage 5/5/03 – 6/16/03

Decision

I disagree with the carrier's decision to deny the requested therapeutic procedure, muscle testing, range of motion testing.

I agree with the decision to deny myofascial release, and massage, prolonged service on 5/27/03, 5/28/03 and 6/10/03, code 97540 on 5/28/03, and office visit on 5/30/03.

Rationale

The patient apparently suffered a sprain/strain injury of the right hip and back. She was treated with therapeutic modalities and chiropractic treatment. She then started a program of active physical therapy exercises to restore her range of motion, flexibility and strength in the leg and trunk. This was medically appropriate to return the patient to normal functioning. The patient was injured on _____, and she began treatment with chiropractic on 3/18/03. Following six weeks of this treatment program, the patient was started on an active physical therapy program. At that time further chiropractic care and passive modalities would not be necessary or appropriate. Completion of TWCC forms is required for injured workers from a treating physician, and the D.C. completed the form. The records provided for this review do not describe the prolonged service or its medical necessity. The records provided do not indicate if code 97540 was performed. The notes do not list that service. There is no office note for provided for 5/30/03, and none of the notes provided support that charge. Muscle testing and range of motion testing are a necessary part of a patient's rehabilitation program to assess strength and range of motion. The testing is a means to evaluate and document the patient's progress in the program, as well as documenting any deficits that may need further treatment. The office visit on 4/30/03 was necessary for the treating physician to follow the patient's progress and update her work status.

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