

MDR Tracking Number: M5-04-2021-01

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 03-05-04.

The office visit on 11-17-03 was withdrawn by the requester in a letter dated June 24, 2004 from ___ of ___ office. The dates of service identified in this dispute were also identified in the dispute M5-04-2167-01. However the medical necessity issues in that dispute were dismissed because the IRO fee was not paid. Therefore, the requester is eligible to have those dates of service reviewed under M5-04-2021-01 as the IRO fee for this dispute was paid.

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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits (99212 and 99213) and therapeutic exercises (97110) from 10-24-03 through 12-29-03 **were found** to be medically necessary. The one-on-one therapeutic activities (97530), neuromuscular re-education (97112) and manual electrical stimulation (97032) from 10-24-03 through 12-29-03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 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 Order is applicable to dates of service 10-24-03 through 12-29-03 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 29th day of June 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

June 16, 2004

MDR Tracking #: M5-04-2021-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

This patient was injured on his job on ___ when he was working and a heavy object fell into his arms and tractioned his upper extremities, causing immediate pain in the neck. The pain for this patient was limited to the cervical spine. EMG was performed which indicated that there was a C4-5 radiculopathy. MRI of the cervical spine indicated that there was degeneration of the spine in a broadbased appearance. CT was similar in appearance. ESI therapy was utilized on this patient for the pain. There was a past history in this patient of a 1993 surgical fusion without instrumentation. That surgery was noted in the records to have not fully healed. The patient was treated with extensive care by all of his doctors and records do not indicate that MMI has been achieved.

DISPUTED SERVICES

The carrier has denied the medical necessity of office visits, therapeutic exercises, neuromuscular re-education, manual electrical stimulation and one-on-one therapeutic activities.

DECISION

The reviewer agrees with the prior adverse determination regarding one-on-one therapeutic activities, neuromuscular re-education and manual electrical stimulation.

The reviewer disagrees with the prior adverse determination for all other care rendered.

BASIS FOR THE DECISION

Clearly, guidelines are of little help in a complicated case such as this. A patient who is post-surgical and is injured yet again does not fit into the traditional occupational medical models. This patient certainly was injured seriously and there was good documentation that he needed ongoing care for his injury. The ___ reviewer did not find adequate documentation to explain why passive treatment was still being rendered almost 3 years past the date of injury. Also, there is little evidence that this patient require individualized care. Group therapy was more appropriate in this case. The documentation does provide insight that the patient was improving with active treatment through therapeutic exercises. The reviewer would not find that HVLA manipulation would be a reasonable approach in a patient with an unsuccessful fusion. However, such manipulations were performed as a part of the office visits and were not billed separately. The office visits themselves were reasonable and necessary for the recovery of this patient.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, Inc, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,