

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-04-8210.M5

MDR Tracking Number: M5-04-2348-01

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 (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 03-30-04.

The requester withdrew CPT codes 97140 and 97112 for 10-17-03 on correspondence on 6-22-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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. A maximum of three units of therapeutic exercises on 10-14-03 and 10-17-03 **were found** to be medically necessary. The remaining office visits, myofascial release, therapeutic exercises, joint mobilization, neuromuscular re-education, and manual therapeutic techniques from 4/02/03 through 10/17/03 **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 a maximum of three units of therapeutic exercises on 10-14-03 and 10-17-03.

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 13th day of July 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

NOTICE OF INDEPENDENT REVIEW DECISION

June 17, 2004

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

RE: Injured Worker: _____
MDR Tracking #: M5-04-2348-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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. TMF'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 TMF 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 patient sustained a work-related injury on ___ when she extended her right hand, grasped and lifted a chair to move it and heard a pop in her right wrist. The patient experienced increased pain with movement, weakness of the right hand, increased pain with attempted grasping, and swelling of the right wrist and hand. A portion of the patient's treatment included chiropractic adjustments in the form of therapeutic exercises, joint mobilization, myofascial release, neuromuscular re-education, office visits and manual therapy techniques billed from 04/03/03 through 10/17/03.

Requested Service(s)

Therapeutic exercises, joint mobilization, myofascial release, neuromuscular re-education (excluding 10/17/03), office visits and manual therapeutic techniques (excluding 10/17/03) from 04/02/03 through 10/17/03

Decision

It is determined that a maximum of three units of therapeutic exercises on 10/14/03 and 10/17/03 were medically necessary. All other treatments and procedures were not medically necessary.

Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include that home care programs should be initiated near the beginning of care, to include ongoing assessment of compliance and result in fading treatment frequency; that patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue; that supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present; and that evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment.

Generally accepted standards indicate that the patient's condition should have the potential for restoration of function and that the treatment should be specific to the injury and provide for the potential improvement of the patient's condition. Potential for restoration of function is identified by progressive return to function. Without demonstration of objective progress, ongoing treatment cannot be reasonably expected to restore this patient's function and thus can only be deemed medically unnecessary.

No valid documentation was provided to support these standards of care. The treatment records that were submitted indicate that the patient failed to respond to care. On many treatment dates, the patient's status remained the "same" since initiating care. On all treatment dates, the patient continued to have difficulty standing, pushing, pulling, reaching, lifting, carrying, climbing, sleeping and grasping. According to the doctor's own treatment notes, there was never any significant improvement. Therefore, the records provided lack documentation to support the medical necessity for any of the treatment rendered prior to surgery.

The records also failed to substantiate that the aforementioned services prior to surgery relieved or cured the effects of the injury, promoted recovery or enhanced the employee's ability to return to or retain employment. The patient's non-response to care is documented by the fact that the surgery was ultimately necessary.

Solely on the basis that surgery was performed on 08/25/03, post surgical rehabilitation, in the form of a maximum of three units of therapeutic exercises per date of service, would be indicated for the 10/14/03 and 10/17/03 dates of service. There is no documentation to support the medical necessity of the office visits on those two dates nor neuromuscular re-education or manual therapy technique on 10/14/03.

Sincerely,