MDR Tracking Number: M5-04-2378-01

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 March 30, 2004.

The IRO reviewed therapeutic exercises (97110) for dates of service 07/02/03 through 07/25/03 that were denied based upon "U".

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.

The IRO determined that only two units of therapeutic exercises (97110) daily from 07/02/03 through 07/25/03 **were** found to be medically necessary. Therapeutic exercises (97110) in excess of two units **were** not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the therapeutic exercises.

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.

On July 5, 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 97750-FC for date of service 08/13/03 was listed on the Table of Disputed Services; however, the requestor listed no dollars as in dispute. Therefore, this CPT Code will not be reviewed.

- CPT Code 97545-WH-AP (64 hours) for dates of service 07/28/03 through 08/15/03 and 08/18/03 through 08/20/03 and 08/18/03 through 09/09/03 denied as "F, N". Per Rule 134.202(e)(5)(A)(i) and 134.202(e)(5)(C) submitted work hardening notes support services were rendered as billed. Reimbursement in the amount of $4,096.00 ($64.00 x 64) is recommended.

- CPT Code 97545-WH-AP (4 hrs) for dates of service 08/14/03 through 08/15/03 denied as "F". Per Rule 134.202(e)(5)(A)(i) and 134.202(e)(5)(C) reimbursement in the amount of $256.00 ($64.00 x 2) is recommended.

- CPT Code 97545-WH –AP (6 hrs.) for dates of service 08/21/03 through 08/25/03 denied as "F, N". Per Rule 134.202(e)(5)(A)(i) and 134.202(e)(5)(C) requestor did not submit work hardening notes to support services were rendered as billed. Reimbursement is not recommended.

- CPT Code 97546-WH-AP (97 hours) for dates of service 07/28/03 through 08/15/03 and 08/18/03 through 08/20/03 and 08/18/03 through 09/09/03 denied as "F, N". Per Rule 134.202(e)(5)(A)(i) and 134.202(e)(5)(C) submitted work hardening notes support services were rendered as billed. Reimbursement in the amount of $6,208.00 ($64.00 x 97) is recommended.

- CPT Code 97546-WH-AP (9 hrs) for dates of service 08/14/03 through 08/15/03 denied as "F". Per Rule 134.202(e)(5)(A)(i) and 134.202(e)(5)(C) reimbursement in the amount of $576.00 ($64.00 x 9) is recommended.

- CPT Code 97546-WH –AP (15 hrs.) for dates of service 08/21/03 through 08/25/03 denied as "F, N". Per Rule 134.202(e)(5)(A)(i) and 134.202(e)(5)(C) requestor did not submit work hardening notes to support services were rendered as billed. Reimbursement is not recommended.

This Decision is hereby issued this _9th_____ day of __October_____, 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

ORDER

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 07/02/03 through 08/20/03 and 08/18/03 through 09/09/03 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 Order is hereby issued this _9th__ day of _October_____ 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/mf
Enclosure: IRO Decision

June 15, 2004

NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter

RE: MDR Tracking #: M5-04-2378-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ------. The patient reported that while at work he was involved in a motor vehicle accident. The patient reported that he injured his cervical spine, head, right shoulder and chest. A MRI of the cervical spine performed on 6/6/03 revealed a mild 2mm posterior central disc protrusion at C6-C7. On 6/9/03 the patient underwent x-rays of the cervical spine, chest and left shoulder that revealed postural changes of the cervical spine, and unremarkable internal and external rotation projections of the left shoulder. The treating diagnoses for this patient have included cervical disc protrusion, right shoulder nerve root plexus disorder, headache, and abdominal pain. Treatment for this patient's condition has included active and passive therapies that included heat/cold packs, and electrical muscle stimulation, and medications. The patient has also participated in a work conditioning/hardening program.

Requested Services

Therapeutic Exercises from 7/2/03 through 7/25/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Daily Notes 7/28/03 – 9/9/03
2. Interim FCE 8/13/03
3. MRI report 6/6/03
4. X-Ray reports 6/9/03

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his back, head, right shoulder and chest. The ------ chiropractor reviewer also noted that the diagnoses for this patient have included cervical disc protrusion, right shoulder nerve root plexus disorder, headache, and abdominal pain. The ------ chiropractor reviewer further noted that treatment for this patient's condition has included active and passive therapies that have included heat/cold packs, and electrical muscle stimulation, medications and a work conditioning/hardening program. The ------ chiropractor reviewer indicated that the patient spent approximately 30 minutes on therapeutic exercises that involved the injured area (neck/mid back). The ------ chiropractor reviewer noted that the patient had been diagnosed with a cervical disc condition and that he had been treated with bicycle and treadmill exercises. The ------ chiropractor reviewer explained that bicycle and treadmill exercises are not appropriate treatment for a cervical disc disorder. The ------ chiropractor reviewer also explained that this patient's treatment needs to be more focused on the injured body parts and not treat the out of shape person who could exercise daily on his own without supervision. Therefore, the ------ chiropractor consultant concluded that two units of therapeutic exercises daily from 7/2/03 through 7/25/03 were medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department