

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 05/03/04.

The IRO reviewed office visits (99212 & 99213), neuromuscular re-education (97112), therapeutic activities (97530), and therapeutic exercises (97110) rendered from 01/21/04 through 02/04/2004 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

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 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 July 19, 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 (2 units) for date of service 01/28/04 denied as "G – Global". According to Rule 133.304 (c) the carrier did not specify which service the range of motion was global to, therefore it will be reviewed according to the Medicare Fee Schedule. Per the Medicare Fee Schedule times 125% reimbursement in the amount of \$52.80 ($\$21.12 \times 125 = \26.40×2) is recommended.
- CPT Code 95833 for date of service 02/02/04 denied as "G – Global". According to Rule 133.304 (c) the carrier did not specify which service the manual muscle testing was global to, therefore it will be reviewed according to the Medicare Fee Schedule. Per the Medicare Fee Schedule times 125% reimbursement in the amount of \$44.99 ($\35.99×125) is recommended.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay **\$97.79** for 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 Decision is applicable for dates of service 01/28/04, CPT Code 95851 and 02/02/04, CPT Code 95833 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 8th day of October 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION

Date: September 28, 2004

RE:

MDR Tracking #: M5-04-2843-01

IRO Certificate #: 5242

_____ 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 proposed 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 Chiropractic reviewer who has an ADL certification. The reviewer 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.

Submitted by Requester:

- Notice of IRO assignment and pre-payment invoice
- Medical dispute resolution request/response
- Table of disputed dates of service 1/28/04 through 2/4/04 (please keep in mind that the disputed dates of service actually ran from 1/24/04 through 2/4/04)
- Letter from _____ dated 4/30/04 (this was essentially a request for medical dispute resolution)
- Table of disputed dates of service 1/21/04 through 1/28/04
- Faxed transmittal regarding a request for reconsideration to the insurance carrier
- Several other requests or letters for request of reconsideration dated 3/15/04 as well as 3/12/04
- MRI scan report of the lumbar spine dated 12/8/03
- MRI report of the left ankle without contrast of 1/9/04
- Ankle x-ray report of 12/15/03
- Chiropractic daily notes and examinations dated 12/15/03, 1/24/04, 1/26/04, 1/28/04, 1/30/04, 2/17/04 (this note was a work hardening screening exam).
- Other chiropractic daily notes and rehabilitation notes were reviewed for dates of service to include 2/2/04 and 2/4/04

Submitted by Respondent:

- None

Clinical History

According to the documentation submitted for review, the claimant reportedly fell from a ladder while taking inventory, thus causing injury to her back and left ankle. It was reported she fell from a surface 2-4 feet high and hit her back and then it is stated she landed on her back. There is a difference between hitting your back and landing on your back. There was no significant past medical history. The claimant did report a right hip injury in _____. It appears the claimant initiated chiropractic care on 12/15/03. It was mentioned the claimant saw another health care provider for treatment related to the injury before consulting with the treating chiropractor on 12/15/03. The claimant then further stated she fell backwards on a ladder hitting her low back on a shelf and her left ankle was reportedly caught between the steps of the ladder when she fell. This would be more in line with a low back contusion if she fell backwards onto a shelf. The MRI of the lumbar spine only showed a 1mm tiny bulge at the L3/4 level. The remaining levels were normal. The MRI of the left ankle was suggestive of talofibular sprain only. There was mild to moderate joint effusion. Left ankle x-rays were reported as normal. The claimant underwent chiropractic care to consist of neuromuscular re-education and various floor exercises and strengthening exercises. A work hardening screening exam of 2/17/04, which falls beyond the disputed dates of service, revealed the claimant to have a Roland-Morris pain disability index score which indicated that she was either bed bound or exaggerating. The claimant also self perceived herself as having a severe disability and on Oswestry, her score was a 62 indicating that she perceived herself as having a crippling self perceived disability. There was no mention at all of any type of pain scale until 2/4/04 at which time the claimant's low back pain was rated a 6/10 and her ankle pain was rated a 2/10. Range of motion and strength testing was reportedly done; however, there have been no numbers associated with the lumbar range of motion and ankle range of motion testing provided in the documentation.

Requested Service(s)

The medical necessity of the outpatient services including office visits to include 99212 and 99213 as well as neuromuscular re-education and therapeutic activities and exercises from 1/21/04 through 2/4/04. I have been asked not to review the range of motion measurement for 1/28/04 and the muscle testing of 2/2/04.

Decision

I agree with the insurance carrier and find that the services in dispute were not medically necessary.

Rationale/Basis for Decision

This is mainly a documentation problem. The documentation revealed the presence of a minor injury and a minimal amount of objective documentation throughout the chiropractic documentation did not justify the treatment that has been rendered. Treatment must mirror the intensity or severity of the injury and it was quite clear that the intensity of the treatment did not correlate at all with the minimal amount of injury documented. The initial objective data from the chiropractor of 12/15/03 reflected minimal objective evidence of injury that would warrant more than 4-6 weeks of treatment in totality. In addition the MRI of the ankle revealed an ankle sprain/strain for which minimal supervised treatment is usually needed. The lumbar MRI revealed a tiny 1mm disc bulge at L4/5. I found that many, if not all, of the documented low back findings as reported by the chiropractor were nonspecific, mild and commonly exist in the non-injured general adult population. These findings included various joint fixations and bilateral muscle tightness. In addition the claimant grossly exaggerated her condition on the 2/17/04 evaluation such that it was documented that she perceived herself as bed

bound or exaggerating. According to the Roland-Morris pain disability index, the claimant perceived herself as bed bound or was exaggerating. Please keep in mind that the claimant felt this way after several weeks or even months of the excessive chiropractic physical therapy for what was obviously documented to be mild ankle and lumbar sprain/strain injury. The claimant also perceived herself as having a crippling self perceived disability on Oswestry scoring which is far beyond what the objective data was suggesting. In fact, the chiropractic note of 12/15/03 revealed a completely normal neurological and strength presentation regarding the lower extremity and low back musculature. The rest of the objective data during the daily chiropractic notes was limited to various joint fixations and palpatory pain. There were no visual analog scale or pain scales until 2/4/04. There was no initial pain scale noted by which to compare the 2/4/04 pain scale values. There were no ranges of motion documented, although range of motion testing was done. There was no evidence at all of objective progress. There was no documentation to support that the claimant could not have been placed back at light duty within days of the injury. I could understand that the claimant was required to climb ladders as part of her inventory job; however, the claimant stated that she climbs ladders 8 hours per day and I find this hard to believe. I am sure appropriate light duty employment could have been arranged given the mild ankle/sprain injury and mild low back contusion sprain/strain event. At any rate, the care that has been rendered including hours of therapeutic exercises and neuromuscular re-education for a mild sprain/strain injury has grossly exceeded the nature and extent of the injury.