

MDR Tracking Number: M5-04-3165-01

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, 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 May 21, 2004.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, neuromuscular re-education, therapeutic exercises, myofascial release, and joint mobilization for dates of service 07/28/03 through 07/31/03 were not medically necessary. 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 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 9, 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 19 days of the requestor's receipt of the Notice.

The issues not denied as medically necessary were denied as "R"; however, review of the TWCC database reveals that there were no TWCC-21's filed; therefore, these dates of service will be reviewed according to Rule 134.202 and will be paid, if warranted, according to the Medicare Fee Schedule. Other denials include "855-010 – NC (non-covered) procedure or service, payment denied \$0.00 and 920-002 – In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance".

- CPT Code 99213 for dates of service 08/18/03, see denial reason above, and 09/25/03, an EOB was not submitted by either party; therefore, this date of service will be reviewed per Rule 134.202. Per Rule 134.202(b) & (c)(1) submitted relevant information supports services were rendered as billed. Reimbursement in the amount of \$110.62 ($\$52.17 \times 125\% = \$65.21 + \45.41, amount requestor billed) is recommended.
- CPT Code 97110 (64 units total) for dates of service 08/18/03 through 09/24/03, see denial reason above. Consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all of the Commission requirements for proper documentation.

The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement is not recommended.

- CPT Code 97140 (34 units) for dates of service 08/18/03 through 09/25/08, see denial reasons above. Per Rule 134.202(b) & (c)(1), submitted relevant information supports services were rendered as billed. Reimbursement in the amount of \$1,152.60 ($\$27.12 \times 125\% = \33.96×34) is recommended.
- CPT Code 97112 (15 units) for dates of service 08/18/03 through 09/25/08, see denial reasons above. Per Rule 134.202(b) & (c)(1), submitted relevant information supports services were rendered as billed. Reimbursement in the amount of \$550.35 ($\$29.35 \times 125\% = \36.69×15) is recommended.
- CPT Code 99212(15 units) for dates of service 08/20/03 through 09/24/03, see denial reasons above. Per Rule 134.202(b) & (c)(1), submitted relevant information supports services were rendered as billed. Reimbursement in the amount of \$696.15 ($\$37.13 \times 125\% = \46.41×15) is recommended.

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 08/18/03 through 09/25/03 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 October 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3165-01
Name of Patient:	
Name of URA/Payer:	Pain & Recovery Clinic
Name of Provider: (ER, Hospital, or Other Facility)	Pain & Recovery Clinic
Name of Physician: (Treating or Requesting)	Warren B. Dailey, MD

July 23, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Rosalinda Lopez, Texas Workers Compensation Commission

CLINICAL HISTORY

This is a 20 year old gentleman who fell and sustained an injury to the left elbow. Six days later he was evaluated by Dr. Roberts who noted lateral joint pain at the level of the radial head. Radiograph noted a "hairline" fracture and this was properly treated with a posterior splint. The left knee was also problematic, a contusion was noted and this was the diagnosis made. Within six months an assessment of maximum medical improvement was made and a 2% impairment rating assigned.

At the same time an evaluation was undertaken by Dr. Dailey, the orthopedist. Dr. Roberts noted a left upper extremity injury and Dr. Dailey noted a bilateral upper extremity injury.

It is not clear why, but MRI studies were completed of the elbow and this noted a healed fracture and a slight radial head displacement.

In March 2003 Dr. Mohamed entered the treatment plan diagnosis of bilateral elbow and bilateral knee pain (please remember that only the left knee was injured). Electrodiagnostic studies were normal. A protocol of injections and topical NSAIDs was started.

In June 2003 maximum medical improvement was noted and an 8% impairment rating assigned.

REQUESTED SERVICE(S)

99213, 97110, 97250, 97265 and 97112 for dates of service 7/28 through 7/31/03.

DECISION

Denied. This care is not reasonable and necessary or clinically indicated.

RATIONALE/BASIS FOR DECISION

For the most part, it is the same diagnosis codes used three times a week for five weeks. However, only three days (7/28/30/31/03) are under consideration. The first code, 99213, is for a patient visit that requires evaluation for an expanded problem and expanded history. The diagnosis was made and there was no intervening problems that required an expanded problem focused history or expanded problem focused examination or any new decision making on a three times a week basis for the dates noted. This is clearly excessive billing.

The second code 97110 requires one-on-one contact. The post-injury treatment for an intra-articular (meniscal) lesion would not require such intensive interaction. In that there had been a number of therapy visits, and noting the types of exercises involved to the knee injured patient; the proper procedures would have been almost second nature and completely memorized. This level of interaction would not be required two months after the date of injury.

The remaining codes, myofascial release, joint mobilization, and neuromuscular re-education are related to chiropractic care. Chiropractic treatment is the subject of much debate and has only shown very limited efficacy in studies. Moreover, these types of modalities are not indicated for radial head fractures or knee contusions.

Therefore, noting that the physical examination initially reported by Dr. Roberts noted a radial head fracture; and the treatment would be posterior splinting and range of motion periodically with removal of the splint in a two to four week time frame; and that the MRI obtained shortly thereafter noted the radial head fracture; the daily progress notes are fairly boilerplate indicating no expanded problem assessment or evaluation was completed or indicated. Also one does not do ultrasound in a fracture situation. The prevailing standard of care for the radial head fracture does not include joint mobilization or neuromuscular re-education. The care being discussed was excessive, not reasonable and necessary and not clinically indicated. The determination made by the carrier is endorsed.