

MDR Tracking Number: M5-04-3361-01

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. This dispute was received on 9-2-03.

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 office visits, therapeutic procedures-group, physical performance test, range of motion, therapeutic exercises, myofascial release, supplies and materials, and joint mobilization for 9-4-02 through 12-4-02 were not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute 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 9-15-04, 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.

- The carrier denied CPT Code 99080-73 with a V for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requester submitted relevant information to support delivery of service. Recommend reimbursement of CPT Code 99080-73 for dates of service 10-8-02 and 12-3-02. **Total reimbursement is \$30.00.**
- The services on from 1-27-03 through 4-11-03 were denied as "E" – this claim is not compensable. The Benefit Review Conference on 5-17-04 found the claim compensable. Therefore this review will be per the MFG only.
 - According to the 1996 *Medical Fee Guideline*, the MAR for CPT Code 99213 is \$48. Recommend reimbursement for dates of service 1-27-03, 2-4-03, 2-13-03, 2-18-03 and 4-11-03. **Total reimbursement is \$240.00.**
 - According to the 1996 *Medical Fee Guideline*, the MAR for CPT Code 97250 is \$43. Recommend reimbursement for dates of service 1-27-03, 2-4-03, 2-13-03, 2-18-03 and 4-11-03. **Total reimbursement is \$215.00.**
 - According to the 1996 *Medical Fee Guideline*, the MAR for CPT Code 97265 is \$43. Recommend reimbursement for dates of service 1-27-03, 2-4-03, 2-13-03, 2-18-03 and 4-11-03. **Total reimbursement is \$215.00.**
 - The requester billed \$40 for CPT Code 99070 - Wrist Brace. Recommend reimbursement for dates of service 2-13-03 and 2-27-03. **Total reimbursement is \$80.**
 - According to the 1996 *Medical Fee Guideline*, the MAR for CPT Code 97124 is \$28. However, the requester billed \$20.00 Recommend reimbursement for date of service 2-18-03 of \$20.00. **Total reimbursement is \$20.00.**
 - According to the 1996 *Medical Fee Guideline*, the MAR for CPT Code 97024 is \$21. Recommend reimbursement for dates of service 2-18-03 of \$21.00. **Total reimbursement is \$21.00.**

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 10-8-02 through 4-11-03 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 4th day of October, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

September 9, 2004

Rosalinda Lopez
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 #: M5-04-3361-01
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 care. 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 51 year-old female was injured while working in a repetitive position at the gizzard station at a chicken processing company. As she was scrubbing the gizzards there was a gradual exacerbation of pain in both hands that radiated up the arms to the shoulders. Her diagnosis is carpal tunnel syndrome. She has been treated with medications and therapy.

Requested Service(s)

99213 – office visit, 97150 – therapeutic procedures-group, 97750MT – physical performance test, 99214 – office visit, 95851 – range of motion, 97110 – therapeutic exercises, 97250 – myofascial

release, 99070 – supplies and materials, 99212 – office visit, and 97265 – joint mobilization for dates of service 09/04/02 through 12/4/02

Decision

It is determined that the office visits, therapeutic procedures-group, physical performance test, range of motion, therapeutic exercises, myofascial release, supplies and materials, and joint mobilization for the dates of service 09/04/02 through 12/4/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Medical record documentation does not indicate the necessity for the services in question. 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: an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care as time progresses; home care programs initiated near the beginning of care, including ongoing assessments of compliance and results in fading treatment frequency; formal assessment of the patient and reassessment periodically to insure that the patient is moving in a positive direction in order for the treatment to continue; provision of supporting documentation for additional treatment when exceptional factors or extenuating circumstance are present; and provision of evidence of objective functional improvement to establish reasonableness and medical necessity of treatment. Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment.

In this case, medical documentation does not indicate an objective or functional improvement in this patient's condition. In fact, the patient's pain rating did not improve at the completion of the disputed treatment and the right shoulder and left wrist ranges of motion actually decreased during this timeframe.

Therapeutic exercise may be performed in a clinic one-on-one, in a clinic in a group, at a gym or at home with the least costly of these options being a home program. A home exercise program is also preferable because the patient can perform them on a daily basis. On the most basic level, the provider has failed to establish why the services were required to be performed one-on-one. Therefore, the office visits, therapeutic procedures-group, physical performance test, range of motion, therapeutic exercises, myofascial release, supplies and materials, and joint mobilization for the dates of service 09/04/02 through 12/04/02 were not medically necessary for the treatment of the patient's medical condition.

Sincerely,