

MDR Tracking Number: M5-04-3482-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 4-29-04.

The IRO reviewed FCE, office visits w/manipulations, myofascial release, therapeutic exercises, electrical stimulation (unattended), hot/cold packs, chiropractic manipulations, manual therapy technique, supplies and materials from 5-8-03 to 12-22-03.

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 paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 6-3-04, 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.

Code 99080-73 was billed for dates of service 5-23-03 and 6-2-03 and denied as unnecessary medical. The TWCC-73 is a required report and not subject to an IRO Review. Per Rule 129.5 (d)(2), "the doctor shall file a Work Status Report when the injured employee experiences a change in work status or a substantial change in activity restrictions." Review of the TWCC-73 indicated a change in the injured worker's work status. Therefore, the requestor is entitled to reimbursement.

- Code 99080-73 – Per Rule 129.5, the MAR is \$15.00. Recommend reimbursement of \$15.00 x 2 days = \$30.00.

## ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 Order is applicable for dates of service 5-23-03 and 6-2-03 in this dispute.

This Order is hereby issued this 6th day of October 2004.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

August 9, 2004

Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

Re: Medical Dispute Resolution  
MDR #: M5-04-3482-01  
TWCC#:  
Injured Employee:  
DOI:  
SS#:  
IRO Certificate No.: 5055

Dear

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

#### **REVIEWER'S REPORT**

##### **Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: consultations and office visits, daily treatment logs, FCE, physiatric evaluation & notes, neurological consult, Rx, and radiology reports.

**Clinical History:**

The patient underwent extensive physical medicine treatments after injuring his cervical spine at work on \_\_\_\_.

**Disputed Services:**

FCE, level III office visits w/manipulations, myofascial release, therapeutic exercises, electrical stimulation-unattended, hot/cold pack therapy, chiropractic manipulative treatment-spinal 1-2 areas, manual therapy technique, supplies & materials from 05/08/03 through 12/22/03.

**Decision:**

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

**Rationale:**

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:

- (A) As time progresses, there should be an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care.
- (B) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency.
- (C) 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.
- (D) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present.
- (E) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment.

According to the Medicare Guidelines, if a patient's expected restoration potential is insignificant in relation to the extent and duration of the physical medicine services required to achieve such potential, the services are not considered reasonable or necessary. In this case, the medical records indicate that the patient obtained no relief from the treatments, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to employment.

The patient's non-response to care is documented by both subjective and objective findings. On 02/25/03, the patient's pain rating was 4 and after 10 weeks of care on 05/09/03, the patient's subjective pain rating had increased to 5. There was also no improvement in the patient's cervical ranges of motion from the initial examination on 02/24/03, to the follow-up examinations on 03/25/03 and 04/22/03, or to the functional capacity evaluation performed on 05/08/03. Moreover, right cervical compression testing remained positive on 04/22/03.

Therapeutic exercises 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. Furthermore, even if the extensive one-on-one therapy had been medically necessary, it would not have been needed for the duration of time in this case and certainly not past the 31 active and passive treatments performed over the 10 week period from 02/25/03 through 05/07/03.

Sincerely,