

MDR Tracking Number: M5-04-3588-01

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 June 21, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the issues of medical necessity. The IRO found that the therapeutic exercises from 7-14-03 through 08-06-03, office visit 99212 on 07-14-03, chiropractic manipulation on 08-01-03 and 08-04-03, and office visits 99213 on 08-08-03, 08-29-03, 09-30-03 and 10-31-01 **were** medically necessary. The IRO found the remainder of the services not medically necessary. Therefore, the requestor is not entitled to reimbursement 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-22-04, 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 following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
07-11-03	E0730	\$125.00	\$0.00	M	DOP	1996 MFG Rule133.1(a)(8)	The requestor did not submit documentation that discusses, demonstrates, and justifies that the payment amount being sought for the E0730 is a fair and reasonable rate of reimbursement in accordance with Rule133.1(a)(8). Therefore, no reimbursement is recommend.
08-01-03	99213-25 98940	\$65.00 \$50.00	\$0.00 \$0.00	No EOB	\$59.00 \$30.14	Medicare Fee Schedule Rule 134.202	Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed services rendered 08-01-03 will be reviewed according to the Medicare Fee Schedule. Reimbursement is recommended in the amount of \$89.14.

08-04-03 08-08-03	98940 98940	\$50.00 \$50.00	\$0.00 \$0.00	No EOB	\$30.14 \$30.14	Medicare Fee Schedule Rule 134.202	Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed services rendered 08-04-03 will be reviewed according to the Medicare Fee Schedule. Reimbursement is recommended in the amount of \$60.28.
08-11-03	97140-59	\$45.00	\$0.00	F	\$30.90	Medicare Fee Schedule Rule 134.202	The requestor submitted relevant documentation to support services billed. CPT code 97140-59 will be reviewed in accordance with the Medicare Fee Schedule. Recommend reimbursement of \$30.90.
08-13-03	98940 97140-59	\$50.00 \$45.00	\$0.00	No EOB	\$30.14 \$30.90	Medicare Fee Schedule Rule 134.202	Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed services rendered 08-04-03 will be reviewed according to the Medicare Fee Schedule. Reimbursement is recommended in the amount of \$61.04.
08-15-03	97140-59	\$45.00	\$0.00	No EOB	\$30.90	Medicare Fee Schedule Rule 134.202	Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed services rendered 08-15-03 will be reviewed according to the Medicare Fee Schedule. Reimbursement is recommended in the amount of \$30.90.
08-18-03	97140-59	\$45.00	\$0.00	No EOB	\$30.90	Medicare Fee Schedule Rule 134.202	Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed services rendered 08-18-03 will be reviewed according to the Medicare Fee Schedule. Reimbursement is recommended in the amount of \$30.90.

08-20-03	97140-59	\$45.00	\$0.00	No EOB	\$30.90	Medicare Fee Schedule Rule 134.202	Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed services rendered 08-20-03 will be reviewed according to the Medicare Fee Schedule. Reimbursement is recommended in the amount of \$30.90
TOTAL							The requestor is entitled to reimbursement of \$334.60.

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) and in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); 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 07-11-03 through 08-20-03 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 29th day of October 2004.

Patricia Rodriguez
 Medical Dispute Resolution Officer
 Medical Review Division

PR/pr
 Enclosure: IRO Decision



7600 Chevy Chase, Suite 400
 Austin, Texas 78752
 Phone: (512) 371-8100
 Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 24, 2004

AMENDED DECISION

Requester/ Respondent Address : Rosalinda Lopez
 TWCC
 7551 Metro Center Drive, Suite 100, MS-48
 Austin, TX 78744-16091

RE: Injured Worker:

MDR Tracking #: M5-04-3588-01

IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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 physician 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.

Documents reviewed from the provider:

- Letter of position from the treating doctor
- A previous response to denials
- Daily notes and reports for the dates of service in question
- CT report.

Documents reviewed from the carrier:

- A summary of events, reviews from Philip Osborne, M.D.
- Reviews from Melissa Tonn, M.D.
- Review from Michael Hamby, D.C.
- Review from Bobby Enkvetchakul, M.D.
- Review by Brad Hayes, D.C.
- The E1
- Daily notes from treating doctors
- Narrative reports
- Diagnostic reports
- The carrier also submitted documentation for services submitted beyond the dates of service in question.

Clinical History

According to the supplied documentation, it appears the claimant sustained an injury to his low back while lifting boxes of water at work on _____. The claimant was evaluated by Marjan Malekzadeh, D.C. the following day and given the diagnoses of a sprain/strain with myofascitis. Chiropractic therapy was begun and the claimant was removed from the workforce. On 06/27/2003, plain film x-rays revealed a transitional L5 vertebrae with a small rudimentary disc. On 09/18/2003 the claimant was seen by Hassan Chahadeh, M.D. for an evaluation. Dr. Chahadeh recommended a facet joint injection. Extensive chiropractic therapy was performed. Passive therapy was discontinued and active therapy was continued. The documentation supplied from the carrier continues past the date of service in question, but was not reviewed.

Requested Service(s)

Please review and address the medical necessity of the outpatient services listed as: office visits (99211, 99212, 99212-25, 99213-25, 99214), (97110) therapeutic exercises, (98940) chiropractic manipulation, (97140-59) manual therapy, (97035) ultrasound, (G0283) electrical stimulation unattended, (99080) required report rendered between 07/14/2003 and 11/12/2003.

Decision

I agree with the treating doctor and disagree with the insurance company that the dates of service with the following codes were medically necessary: 07/14/2003 (99212) and (97110), 07/16/2003 (97110), 07/18/2003 (97110), 07/23/2004 (97110), 07/25/2003 (97110), 07/28/2003 (97110), 07/30/2004 (97110), 08/01/2004 (98940 and 97110), 08/04/2003 (98940 and 97110), 08/06/2004 (97110), 08/08/2003 (99213), 08/29/2003 (99213 max), 09/30/2003 (99213 max) and 10/31/2003 (99213 max). I agree with the insurance company that the remainder of services rendered were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, the claimant sustained an injury on _____. The claimant began care the following day on _____. An initial trial of 6-8 weeks is seen as medically necessary to reduce the claimant's symptoms. The notes support the care through 08/06/2003 in reducing the claimant's pain. On an evaluation dated 07/11/2003, Dr. Malekzadeh reported the claimant's subjective complaints were reduced to a 2/10 with 10 being the worst. On 07/16/2003 the claimant reported his pain was down to a 1/10. Then at the end of an 8-week trial, approximately 08/06/2004, the claimant had progressed enough to transition to a home-based exercise program. Continued therapy is not seen as reasonable or medically necessary in the treatment of the compensable injury. According to **Occupational Medicine Practice Guidelines** (pp 288 2nd edition 2004), "*The strongest medical evidence regarding potential therapies for low back pain indicates that having the patient return to normal activities has the best long-term outcome.*" Since the claimant had improved enough to minimize his symptoms and performed 4 units of therapeutic exercise on a routine basis, then a home exercise program (HEP) and return to normal activities would have been the appropriate treatment plan. Since the chiropractor was the treating doctor in this case, then monthly office visits are seen as reasonable and medically

necessary to evaluate progress and refer as needed. Office visits greater than a 99213 CPT code are not objectively documented.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 24th day of August 2004.

Signature of IRO Employee:

Printed Name of IRO Employee: Deborah Raine