

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-05-2806.M5

MDR Tracking Number: M5-04-4064-01

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 July 29, 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 CPT Codes 99211, 99212, 99213, 97113, 98940, 98941, 97012, 97530, 99078, and 97750-FC 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 August 20, 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.

- CPT Codes 95903-TC, 95904-TC, 95936-TC, and 95926-TC for date of service 09/12/03. Neither party submitted EOBs. Per Commission Rule 133.307(E)(2)(A) a HCFA-1500 was not submitted by the requestor; therefore, MDR can not determine if the requestor billed the insurance carrier in accordance with 134.304(k)(1)(A). Reimbursement is not recommended.
- CPT Code 99080-73 for dates of service 09/18/03, 11/18/03, 12/18/03, 02/19/04, and 03/22/04 denied as "U" or "V". 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. Per Rule 129.5 reimbursement in the amount of \$75.00 (\$15.00 x 5) is recommended.
- CPT Code 97113 for dates of service 10/13/03 and 10/14/03. Neither party submitted EOBs. Per Commission Rule 133.307(E)(2)(A) HCFA-1500s were not submitted by the requestor; therefore, MDR can not determine if the requestor billed the insurance carrier in accordance with 134.304(k)(1)(A). Reimbursement is not recommended.
- CPT Codes 97530, 98940, 97012 for date of service 12/05/03. Neither party submitted EOBs. Per Commission Rule 133.307(E)(2)(A) a HCFA-1500 was not submitted by the requestor; therefore, MDR can not determine if the requestor billed the insurance carrier in accordance with 134.304(k)(1)(A). Reimbursement is not recommended.
- CPT Code 99080-73 for dates of service 01/19/04 and 04/22/04. Neither party submitted EOBs. Per Rule 133.106(f) relevant information supports services were rendered as billed. Reimbursement in the amount of \$30.00 (\$15.00 x 2) is recommended.
- CPT Code 99212 for date of service 01/28/04. Neither party submitted an EOB. Per Commission Rule 133.307(E)(2)(A) a HCFA-1500 was not submitted by the requestor; therefore, MDR can not determine if the requestor billed the insurance carrier in accordance with 134.304(k)(1)(A). Reimbursement is not recommended.
- CPT Code 99362 for date of service 03/30/04. Neither party submitted an EOB. Per Commission Rule 133.307(E)(2)(A) a HCFA-1500 was not submitted by the requestor; therefore, MDR can not determine if the requestor billed the insurance carrier in accordance with 134.304(k)(1)(A). Reimbursement is not recommended.
- CPT Code 99212 for date of service ____ denied as "N". Per Rule 134.202(b) and the Medicare Fee Schedule reimbursement in the amount of \$41.91 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 133.106(f)(1) 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 date of service _____ 09/18/03, 11/18/03, 12/18/03, 01/19/04 02/19/04, 03/22/04, 04/15/04 and 04/22/04 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 22nd day of October 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

September 30, 2004

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 #: M5-04-4064-01
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 46 year-old male injured his low back on ___ when he fell into a large ditch while weed eating. His diagnosis is lumbar radiculopathy. He has been treated with medication, therapy and epidural steroid injections.

Requested Service(s)

Office visits, 97113-Aquatic therapy, chiropractor manipulative treatment, 97012-mechanical traction, 97530-therapeutic activities, 99078-physical educational services-group, 97750-functional condition-physical performance test for dates of service 08/01/03 through 04/22/04 excluding dates of service 09/12/03, 09/18/03, 10/13/03, 10/14/03, 12/05/03, 12/18/03, 01/19/04, 03/22/04, and 03/30/04. Also exclude reviewing 99080 73-special reports on dates of service 11/18/03, 02/19/04 and 04/22/04 and 99212-office visits on dates of service 01/28/04 and 04/15/04. (Excluded dates are marked with FEE and not to be reviewed).

Decision

It is determined that there is no medical necessity for the services in question to treat this patient's medical condition.

Rationale/Basis for Decision

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. Medical record documentation does not indicate why the services were required to be performed one-on-one or why the services were needed for this extended length of time.

Physical medicine treatment requires ongoing assessment of a patient's response to prior treatment and modification of treatment activates to effect additional gains in function. For medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. The patient obtained no significant relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to employment. The patient's lack of recovery is documented by the lack of improvement in his lumbar ranges of motion and the treating doctor's note on 04/06/04, after several months of therapy, the patient "needs to have a surgical consultation for his lumbar injury." Continuation of an unchanging treatment plan and performance of activities that can be performed as a home exercise program are not indicated. Therefore, the office visits, aquatic therapy, chiropractor manipulative treatment, mechanical traction, therapeutic activities, physical educational services-group, and functional condition-physical performance test were not medically necessary to treat this patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn

Attachment