

MDR Tracking Number: M5-04-4083-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on July 29, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. 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 the only issue** to be resolved. The manual therapy techniques (97140) from 12-11-03 through 12-23-03 and the office visit (99213) for 12-29-03 **were found** to be medically necessary. The limb range of motion testing (95831), spinal range of motion testing (95851), office visits (99211), massage therapy (97124), neuromuscular reeducation (97112), and therapeutic exercises (97110) from 12-10-03 through 12-23-03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 12-11-03 through 12-29-03 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 23rd day of September 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-4083-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

September 9, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. 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,

CLINICAL HISTORY

Items Reviewed:

1. Notification of IRO Assignment, Table of Disputed Services, carrier EOBs
2. Narratives from examinations by medical doctor dated 05/16/03 and 11/21/03
3. Script from medical doctor referring patient to "O.T./P.T."
4. Narrative from initial evaluation as well as lumbar and shoulder exam forms, all dated 12/10/03
5. Daily treatment notes from treating doctor for dates of service 12/11/03 through 12/29/03, including therapeutic exercise notes
6. Statement of position on the part of the treating doctor dated 07/20/04
7. General peer review by Dr. G, D.O., dated 10/27/03, along with an addendum dated 12/23/03
8. Report from RME by Dr. P, M.D., dated 05/26/04

Patient is a 62-year-old female mail shop clerk who, on ____ sustained a compensable fall and injured her cervical and lumbar spines as well as her right shoulder. She subsequently received extensive medical and chiropractic care, including physical therapy, and was eventually deemed MMI by her treating doctor at 18% whole-person impairment in June of 1997, and 8% impairment by a designated doctor in August of that same year. Although the records indicate that she has been quite successful managing her condition on her own by participating in a regular home exercise program, despite this, the records also suggest that she has sustained periodic exacerbations and has treated with medical doctors, receiving medication, and also with doctors of chiropractic since that time.

REQUESTED SERVICE(S)

Limb range of motion testing (95831), spinal range of motion testing (95851), office visits (99211 and 99213), manual therapy (97140), massage therapy (97124), neuromuscular reeducation (97112), and therapeutic exercises (97110) for dates of service 12/10/03 through 12/29/03.

DECISION

The manual therapy techniques (97140), and the office visit (99213) on date of service 12/29/03 are approved. All remaining services and procedures are denied.

RATIONALE/BASIS FOR DECISION

The medical records submitted for review adequately document a compensable injury that resulted in a permanent impairment, and as such, the medical necessity for treatment of acute exacerbations was supported. In terms of date of service 12/29/03 specifically, the records also indicated that the treating doctor performed a spinal manipulation on that patient encounter, further supporting this service. Also, the records sufficiently demonstrated the presence of muscular spasticity and shoulder range of motion reduction, supporting the medical necessity that manual therapy techniques be performed.

However, insofar as the supervised therapeutic exercises were concerned, this patient had been participating in a home exercise program for years since her injury of _____. Therefore, the medical necessity for returning to a supervised program at that point was not supported. Further, nothing in either the treating doctor's notes or the referring medical doctor's notes indicated any condition or finding that warranted performing neuromuscular reeducation. In fact, both doctors found deep tendon reflexes, dermatomes, gait, and proprioception to be normal. Therefore, these services were not supported as medically necessary.

Regarding the range of motion tests that were performed on 12/10/03, these were denied because they were components of the initial examination (Evaluation and Management) service performed on the same date. Therefore, the performance of a separate range of motion study for the shoulder and lumbar spine would be duplicative, and as such, medically unnecessary. And finally, regarding massage (97124), this procedure was a component of the manual therapy performed on the same date. Therefore, it was not medically necessary to perform this duplicative service.