

MDR Tracking Number: M5-04-4206-01

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 08-13-04.

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 the office visits, manual therapy, ultrasound, exercises, neuromuscular re-education, and electrical stimulation rendered from 9/24/03 through 10/02/03 and 10/18/03 through 2/12/04 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 September 8, 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 14 days of the requestor's receipt of the Notice.

- **CPT code 99212** for dates of service 10/03/03, 10/07/03, 10/09/03, 10/10/03, and 10/17/03 were denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed service will be reviewed according to the fee guidelines. **Reimbursement is recommended in the amount of \$227.05**
- **CPT code 97140** for dates of service 10/03/03, 10/07/03, 10/09/03, 10/10/03, and 10/17/03 were denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed service will be reviewed according to the fee guidelines. **Reimbursement is recommended in the amount of \$339.00** (2 units per date of service).
- **CPT code 97112** for dates of service 10/03/03, 10/07/03, 10/09/03, 10/10/03, and 10/17/03 were denied by the carrier. Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the reconsideration HCFAs and certified mail receipt reflected proof of billing in accordance with Rule 133.308 (f)(3). The disputed service will be reviewed according to the fee guidelines. **Reimbursement is recommended in the amount of \$183.45.**

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 10/03/03 through 10/17/03 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 27th day of October 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

NOTICE OF INDEPENDENT REVIEW DECISION

October 11, 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 #: M5-04-4206-01
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 53 year-old male slipped on the stairs on ___ causing pain in his knees, neck, and back. His diagnoses include torn meniscus bilateral knees and cervical and lumbar strain with radiculitis. Bilateral knee arthroscopic surgery was performed on 11/11/03. He has been treated with chiropractic modalities, medication, and physical therapy.

Requested Service(s)

Office visits, manual therapy, ultrasound, exercises, neuromuscular reeducation, and electrical stimulation for dates of service 09/24/03 through 10/02/03 and 10/18/03 through 02/12/04.

Decision

It is determined that office visits, manual therapy, ultrasound, exercises, neuromuscular reeducation, and electrical stimulation were not medically necessary for treatment of this patient's medical condition from 09/24/03 through 10/02/03 and 10/18/03 through 02/12/04.

Rationale/Basis for Decision

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.

The treatment records submitted indicate that the patient failed to respond to prolonged and extensive treatment. On many treatment dates the patient reported being "the same", and for all dates in question he continued to have difficulty walking, pushing, pulling, reaching, lifting, carrying, climbing, driving, sleeping, bending, grasping, and squatting. Therefore, according to the doctor's treatment notes, there was never any significant improvement with treatment. The patient's lack of improvement is further documented by the insignificant increases in cervical and lumbar range of motion from 09/12/03 to 01/30/04 and the unchanged pain rating of 10 on a scale of 10 on 08/08/03 and again on 02/06/04. The disputed services thus did not fulfill the statutory requirements of the Texas Labor Code 408.021 for medical necessity since the treatment did not relieve or cure the effects of the injury, did not promote recovery, and did not enhance the employee's ability to return to employment. Therefore, the office visits, manual therapy, ultrasound, exercises, neuromuscular reeducation, and electrical stimulation were not medically necessary for treatment of this patient's medical condition from 09/24/03 through 10/02/03 and 10/18/03 through 02/12/04.

Sincerely,