

MDR Tracking Number: M5-04-4354-01

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 08-26-04.

CPT code 97139 on dates of service 09-25-03 and 10-02-03 were withdrawn on 10-22-04 by the requestor and will not be reviewed by the Medical Review Division.

The IRO reviewed vasopneumatic device rendered on 08-27-03, 09-03-03 and 09-05-03 denied based upon "U".

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.

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 11-05-04, 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.

Review of CPT code 99211, 97035 and 97032 date of service 09-11-03 revealed that neither the requestor nor the respondent submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. Per Rule 133,307(e)(3)(B) the respondent did not submit an EOBs as required. No reimbursement is recommended.

This Findings and Decision is hereby issued this 22nd day of December 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 10/22/04

TWCC Case Number:	
MDR Tracking Number:	M5-04-4354-01
Name of Patient:	
Name of URA/Payer:	Southeast Health Services
Name of Provider: (ER, Hospital, or Other Facility)	Southeast Health Services
Name of Physician: (Treating or Requesting)	James Syvrud, DC

September 30, 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,

Michael S. Lifshen, MD
Medical Director

cc: Rosalinda Lopez, Texas Workers Compensation Commission

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Notification of IRO Assignment, Table of Disputed Services, carrier EOBs;
2. Examination (initial?) dated 08/25/03;
3. Daily treatment notes for dates of service 08/25/03, 08/27/03, 08/30/03, 09/03/03, 09/05/03, 09/08/03, 09/11/03, 09/12/03, 09/25/03, and 10/02/03; and
4. Statement of description of the "Matrix System" along with a place to indicate settings, time of procedure and location of application

Patient is a 52-year-old female who, on ___, fell out of a chair that slipped on a wet floor and injured her right knee. The office note from date of service 08/25/03 stated that the patient had returned to work 2 weeks beforehand and her right knee pain increased while standing to perform her filing duties and when climbing stairs. (No other records were available regarding past treatment history, surgeries if any, or diagnostics to comment further on the history.)

REQUESTED SERVICE(S)

Vasopneumatic device (97016) for dates of service 08/27/03, 09/03/03 and 09/05/03.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

In this case, the treating doctor utilized a "Matrix System" device that he further described as a "Non-invasive Nerve Block and a Vasopneumatic application to decrease localized and radicular pain as well as edema around the injured tissue." However, upon review of the examination and the daily treatment notes, there was no evidence for the findings of edema and/or lymphedema to support the medical necessity of this procedure.

According to a Medicare Policy Statement,¹ “The use of vasopneumatic devices may be considered reasonable and necessary for the application of pressure to an extremity for the purpose of reducing edema. Specific indications for the use of vasopneumatic devices include the reduction of edema after acute injury and lymphedema of an extremity.” Since neither the examination nor the daily treatment notes made specific reference to the presence of lymphedema, the treatment in question was not medically necessary.

¹ Medicare Medical Policy Bulletin Y-1S: Physical Therapy and Rehabilitation Services