

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 9-23-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The office visits, manual therapy, modalities, manipulations and physical therapy testing for 9-25-03 through 5-19-04 **were found** to be medically necessary. The self-care training, therapeutic procedures and physical therapy re-evaluation for 9-25-03 through 5-19-04 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute 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 12-29-04 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.

CPT Code 97140-59 on 5-19-04 was denied with an F – Fee guideline MAR reduction. The EOB shows that the insurance carrier did reimburse the requestor the MAR amount. However, the requestor states that no payment was received. **Recommend reimbursement of \$34.13.**

CPT Code 97124 on 5-19-04 was denied with a G – Global. Per rule 133.304 (c) Carrier didn't specify which service this was global to. **Recommend reimbursement of \$28.40.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 9-25-03 through 5-19-04 as outlined above in this dispute.

This Findings and Decision and Order is hereby issued this 4th day of February, 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA:da

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

December 1, 2004

Amended Letter 02/01/05

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 #: M5-05-0333-01
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 Medicine. 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 44 year old male injured his left shoulder, lower back and neck on ___ when he slipped and fell on a waxed floor. He has been treated with medications, therapy, epidural steroid injections and surgery.

Requested Service(s)

Office visits, manual therapy, modalities, manipulations, self-care training, therapeutic procedures, physical therapy testing, physical therapy re-evaluation for dates of service 09/25/03 through 05/19/04

Decision

It is determined that there is no medical necessity for the self-care training, therapeutic procedures and physical therapy re-evaluation for dates of service 09/25/03 through 05/19/04 to treat this patient's medical condition. However, the office visits, manual therapy, modalities, manipulations and physical therapy testing for dates of service 09/25/03 through 05/19/04 were medically necessary to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation does not indicate the necessity for the self-care training, therapeutic procedures and physical therapy to treat this patient's medical condition. The daily SOAP notes failed to adequately establish the medical necessity for instruction in activities of daily living because it did not mention what was specifically impaired within his daily activities that required training. The physical therapy evaluation performed was a duplicated service and therefore not medically necessary. Therapeutic procedures that do not require "hands-on care" or supervision of a health care provider are not considered medically necessary. Current medical literature states there is no strong evidence for the effectiveness of supervised training as compared to home exercise. Therefore, the self-care training, therapeutic procedures and physical therapy re-evaluation for dates of service 09/25/03 through 05/19/04 were not medically necessary to treat this patient's medical condition.

Several randomized studies have proven the effectiveness of spinal manipulation for patients with cervical spine symptoms and conditions. The medical records also indicate that the patient had flare-ups that warranted the periodic application of modalities and procedures. Office visits and physical therapy testing were also necessary to monitor the ongoing treatment and evaluation of the patient's progress. Therefore, the office visits, manual therapy, modalities, manipulations and physical therapy testing were medically necessary to treat this patient's medical condition for dates of service 09/25/03 through 05/19/04.

Sincerely,

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

GBS:dm
Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-0333-01

Information Submitted by Requestor:

- Letter of Medical Necessity
- Therapy Notes
- Consults
- Peer Review
- Functional capacity evaluation
- Physical Performance Evaluation
- Diagnostic Tests

Information Submitted by Respondent:

- Report of Medical Evaluation
- Peer Review
- Therapy Notes
- Independent Medical Evaluation
- Pain Management
- Functional capacity evaluation
- Impairment Rating
- Diagnostic Tests
- Consults