

MDR Tracking Number: M5-05-0452-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 10/05/04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity for ultrasound, manual therapy technique therapeutic exercises physical performance test, office visits, paraffin bath, hot/cold pack, electrical stimulation unattended, electrodes replacement battery for TENS unit from 2/16/04 through 7/15/04. 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12/07/04, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
2/23/04 3/19/04	99080-73	\$20.00 each DOS	\$-0-	V	\$15.00	Rule 129.5	The TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; therefore, reimbursement in the amount of \$30.00 is recommended (\$15.00 x 2).
TOTAL							The requestor is entitled to reimbursement of \$30.00.

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 is hereby issued this 14th day of January 2005.

Pat DeVries
 Medical Dispute Resolution Officer
 Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 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 Order is applicable for dates of service 2/16/04 through 7/15/04 in this dispute.

This Order is hereby issued this 14th day of January 2005.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/pd

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

TWCC Case Number:	
MDR Tracking Number:	M5-05-0452-01
Name of Patient:	
Name of URA/Payer:	Julio Fajardo, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Julio Fajardo, DC

January 12, 2005

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: Texas Workers Compensation Commission

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Provider's correspondence, examination and treatment notes
2. Rehabilitation Exercises Notes
3. Carrier EOBs
4. Carrier review
5. Functional Testing Reports
6. Operative reports and follow-up examinations
7. Electrodiagnostic studies
8. DME prescriptions

The claimant sustained injuries to the right upper extremity secondary to a work-related injury on ____ when she was assigned additional custodial duties. After failing to respond to conservative treatment measures and after undergoing an NCV/EMG study, she underwent endoscopic carpal tunnel release on 03/10/04. Subsequently, post-operative rehabilitation treatment was performed.

REQUESTED SERVICE(S)

CPT Codes 97035, ultrasound; manual therapy technique; 97110, therapeutic exercises; 97750, physical performance test; 99211-25, office visit; 99212, office visit; 97018, paraffin bath; 99213, office visit; 97010, hot/cold pack; G0283, electrical stimulation unattended; HCPCS codes A4556-NU, electrodes; A4630-NU, replacement battery for TENS unit from 02/16/04 through 07/15/04.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

Physical medicine is an accepted part of a rehabilitation program following an injury and surgery. 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. General expectations include: (A) As time progresses, there should be an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care. (B) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (C) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (D) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (E) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. In this case, the provider certainly fulfilled those criteria.

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains. In this case, there is adequate documentation of

objective and functional improvement in this patient's condition thus making the disputed treatment both indicated and medically necessary.

And finally, the *Guidelines for Chiropractic Quality Assurance and Practice Parameters*¹ Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Again, in this case, the provider discontinued treatment at the appropriate time and referred the patient for surgery.

¹ Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.