

MDR Tracking Number: M5-05-0486-01

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 10-08-04.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 8-27-03 through 10-06-03.

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.

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

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. One unit per visit of manual therapy technique (CPT Code 97140) from 10-09-03 through 11-24-03 **was found** to be medically necessary. The neuromuscular reeducation, therapeutic exercises and office visits from 10-09-03 through 11-24-03 **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 12-07-04, the Medical Review Division submitted a Notice to the 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 carrier denied CPT Code 99080-73 on 10-9-03 and 11-10-03 with an "F" – the Work Status Report was not properly completed. The requestor did submit this report and it was complete per Rule 129.5. **Recommend reimbursement of \$30.00. (\$15.00 x 2 DOS)**

The carrier denied CPT Code 99213 on 11-10-03 with an "F". In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. The requestor billed \$48.23 and the MAR is \$66.19. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge). **Recommend reimbursement of \$48.23.**

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 10-09-03 through 11-24-03 as outlined above 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 19<sup>th</sup> day of January 2005.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

DA/da

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 12/9/04**

TWCC Case Number:	
MDR Tracking Number:	M5-05-0486-01
Name of Patient:	
Name of URA/Payer:	Correct Care Clinic
Name of Provider: (ER, Hospital, or Other Facility)	Correct Care Clinic
Name of Physician: (Treating or Requesting)	Nichole Tran, DC

November 22, 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: Texas Workers Compensation Commission

### CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Notification of IRO Assignment, Table of Disputed Services, copies of Carrier EOBs
2. Copies of HCFAs from treating doctor's office
3. Initial and subsequent narrative office notes from company doctor-referred orthopedist, dated 02/24/03, 03/07/03, 03/26/03, 04/16/03, 05/14/03, and 05/21/03
4. MRI report of left ankle, dated 03/04/03
5. Three phase bone scan report of left ankle, dated 06/30/03
6. Initial evaluation report from treating doctor of chiropractic, dated 06/12/03 and records of two reexaminations dated 08/27/03 and 12/11/03
7. Daily chart notes from treating doctor, from 06/18/03 through 11/24/03
8. Therapeutic exercise charts from 06/12/03 through 10/22/03
9. Initial consultation report from orthopedist, dated 07/14/03
10. Subsequent consultation reports from orthopedist, dated 07/21/03, 08/08/03, 08/22/03, and 09/10/03
11. Functional capacity evaluation dated 10/07/03 and 12/09/03
12. Treating doctor's office statement of position regarding dispute, dated 08/24/04 and letter requesting reconsideration, dated 06/15/04
13. Designated doctor examination and report, dated 10/16/03

14. Impairment rating examination and report from treating doctor, dated 12/11/03
15. Work conditioning weekly progress notes
16. Multiple TWCC-73s, undated, from company doctor-referred orthopedist

Patient is a 38-year-old female machine operator who, on \_\_\_\_\_, became pinned by a forklift between 2 pallets and injured her left ankle. She was originally treated by the company doctor, but on 06/12/03, presented herself to a doctor of chiropractic who began physical therapy and rehabilitation, and during that time, received three steroid injections into her ankle and oral medications. She also participated in a work conditioning program. On 10/16/03, she was seen by a TWCC designated doctor who determined she was not yet at MMI.

#### REQUESTED SERVICE(S)

Manual therapy techniques (97140), neuromuscular reeducation (97112), therapeutic exercises (97110), office visits, and expanded problem-focused (99213) for dates of service 10/9/03 through 11/24/03.

#### DECISION

One unit per visit of manual therapy technique (97140) is approved. All remaining services and procedures within the date range in dispute are denied.

#### RATIONALE/BASIS FOR DECISION

First of all in this case, the records adequately established that the patient had sustained a significant ligamentous injury to her left ankle, and that range of motion remained impaired during the date range in question. Therefore, it was medically necessary to continue providing joint mobilization. However, because the injury was isolated to the left ankle, the diagnosis did not support more than one unit of this service per visit.

Insofar as the neuromuscular reeducation service (97112) was concerned, there was nothing in either the diagnosis or the physical examination findings on this patient *at any time* that demonstrated neuropathology necessitating the application of this service. In fact, in the treating doctor's own notes, it was

written, "Sensory exam is intact. Reflexes are 2+ bilaterally from C5 through L4, and 2/2 for the left S1. Motor exam is 5/5 bilaterally from C5 through S1." Furthermore, there were no findings of proprioceptive alterations that would otherwise render this service medically necessary.

Regarding therapeutic exercises, there was no evidence to support the need for continued monitored therapy. Services that did not require "hands-on care" or supervision by a health care provider are not considered medically necessary services, *even if* they were performed by a health care provider. Continuation of an unchanging treatment plan, performance of activities that can be performed as a home exercise program and/or modalities that provide the same effects as those that can be self applied are not indicated. Any gains obtained in this time period would have likely been achieved through performance of a home program. In fact, current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises." <sup>1</sup> Therefore, since the patient had already participated in 32 visits of supervised therapeutic exercises over a period of 2 ½ months, the doctor failed to adequately support the rationale for continued supervised therapeutic exercises at that point in her care.

And finally, concerning the expanded problem-focused office visits (99213), the medical records failed to document that manipulation was ever performed on any visit. Therefore, based on the diagnosis in this case as well as CPT<sup>2</sup>, there is no support for the medical necessity of providing this level of Evaluation and Management (E/M) service on each and every visit, and particularly not during an established treatment plan.

---

<sup>1</sup> Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.

<sup>2</sup> CPT 2004: *Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),