

MDR Tracking Number: M5-05-0638-01

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 10-26-04.

The IRO reviewed office visits, manual therapy techniques, therapeutic exercises and electrical stimulation-manual rendered from 11-03-03 through 11-26-03 that were denied based upon "V".

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 11-30-04 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 99213 date of service 11-04-03 per an EOB dated 12-12-03 submitted by the respondent has been paid in the amount of \$62.81 by check number 07183761. The respondent's payment was made to a different provider than the requestor. The requestor was contacted and it was verified that this service is still in dispute. This service was denied as a "D" (duplicate) on the original EOB. The service is reviewed per Rule 134.202. The MAR per the Medicare Fee Schedule is \$66.19 (\$52.95 X 125%). However, the requestor billed \$62.81, therefore this is the recommended reimbursement.

CPT code 99080-73 date of service 11-13-03 denied with a "V" for unnecessary medical treatment based on a peer review. The requestor's office has verified that this service has been paid and service is no longer in dispute. The Medical Review Division will not review this service

### **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 effective 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 date of service 11-13-03 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 Findings and Decision and Order are hereby issued this 7th day of January 2005.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

December 23, 2004

Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

Re: Medical Dispute Resolution  
MDR #: M5-05-0638-01  
TWCC#:  
Injured Employee:  
DOI:  
SS#:  
IRO Certificate No.: IRO 5055

Dear Ms. \_\_\_\_:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme  
Secretary & General Counsel

GP:thh

**REVIEWER'S REPORT**  
**M5-05-0638-01**

**Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

- correspondence
- office and physical therapy notes 09/08/03 – 11/28/03
- FCE's 10/06/03 – 11/18/03
- ERGOS evaluation 11/11/03

Information provided by Respondent:

- case reviews 12/11/03 & 03/05/04

Information provided by Orthopedic Surgeon:

- office notes 08/29/03 – 09/04/03
- operative report 09/02/03

Information provided by Orthopedist:

- office notes 09/11/03 – 10/09/03

**Clinical History:**

Patient underwent surgery and post-operative rehabilitation after fracturing right elbow at work on \_\_\_\_.

**Disputed Services:**

Office visits, manual therapy techniques, therapeutic exercises and electrical stimulation-manual, during the period of 11/03/03 thru 11/26/03.

**Decision:**

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

**Rationale:**

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. General expectations include: (A) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (B) 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. (C) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (D) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. 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. In this case, there is no documentation of objective or functional improvement in this patient's condition and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment.

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters*<sup>1</sup> 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." In this case, the four-week had already passed (prior to the disputed treatment) without any material improvement in the patient's condition.

Moreover, the records fail to substantiate that the disputed services fulfilled the statutory requirements<sup>2</sup> for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to or retain employment. Specifically, the claimant reported his pain as increased, the same or unrelieved on 10/27/03, 10/28/03, 10/29/03, 10/30/03 and 11/02/03. The claimant also exhibited a decrease in shoulder range of motion from 10/06/03 to 11/18/03 thus documenting that the continued treatment was non-beneficial and medically unnecessary.

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

<sup>2</sup> Texas Labor Code 408.021