

MDR Tracking Number: M5-05-0659-01

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 August 16, 2004. Per Rule 133.308(e)(1) date of service 08/15/03 was not filed within the 365-day timeframe and MDR has no jurisdiction over this date of service. This dispute was originally docketed as M5-04-4247-01.

The IRO reviewed office visits, muscle testing, range of motion testing and therapeutic procedures that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on 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.

The office visits (99213), therapeutic exercises from 09/12/03 through 06/03/04 and the range of motion testing (95851) and muscle testing (958311) on 09/22/03 **were** found to be medically necessary. The range of motion testing (95351) and muscle strength testing (95831) on 10/06/03 and the office visits (99211) from 09/12/03 through 06/03/04 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for office visits, muscle testing, range of motion testing and therapeutic procedures.

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.

On September 16, 2004, 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.

On September 10, 2004, Medical Dispute Resolution received a letter from the healthcare providers representative withdrawing the fee issues. Although CPT Code 99080-73 is a fee issue the insurance carrier denied the report with a PEC code of "V", making it necessary for MDR to review this code.

- CPT Code 99080-73 for date of service 06/30/04 denied as "V". Per Rule 129.5 the Work Status Report is a required report; therefore, MDR has jurisdiction. Per Rule 133.106(f)(1) reimbursement in the amount of \$15.00 is recommended.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees outlined above as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- 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 to dates of service 09/12/03 through 06/03/04 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 Order is hereby issued this 5th day of November 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

Enclosure: IRO decision

October 27, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE:

Old MDR Tracking #: M5-04-4247-01

New MDR Tracking #: M5-05-0659-01

TWCC #:

Injured Employee:

Requestor:

Respondent:

----- Case #:

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ----- external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ----- chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 44 year-old female who sustained a work related injury on -----. On 7/10/02 the patient underwent right carpal tunnel release followed by postoperative rehabilitation beginning 8/8/02. The patient was initially treated with 9 sessions of rehabilitation and subsequently was treated with 12 addition sessions. The patient reportedly developed complex regional pain syndrome (CRPS) and was initially treated with medication and subsequently underwent stellate ganglion blocks with immediate follow up therapy after each injection. The diagnoses for this patient have included CRPS, type I, bilateral in hands and forearms, and myofascial pain disorder, upper back and neck. The patient has been treated with further injections and physical therapy.

Requested Services

Office visits, muscle testing 95831, 95851 range of motion, and 97110 therapeutic procedures from 9/12/03 through 6/3/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Letter of Reconsideration 12/30/03
2. Second Opinion 4/1/03
3. Follow Up Evaluations 12/19/02 - 2/25/04
4. Pain Management Notes 11/4/02 and 11/26/02
5. Treatment Logs 8/5/02 – 1/10/03
6. Treatment Notes 6/4/03 – 6/3/04

Documents Submitted by Respondent:

1. No documents submitted

Additional Records Used by the Reviewer to Reach a Decision:

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Statement of Position from treating doctor 7/13/04
3. Letter of Reconsideration 4/29/03
4. Copy of carrier selected 2nd opinion report 4/1/03
5. Impairment rating report and TWCC-69 6/11/04
6. X-ray report 6/10/04
7. Operative reports
8. Follow up treatment notes, multiple dates
9. Psychological Treatment Summary and Service request 12/20/03
10. SOAP and daily therapy notes, multiple dates
11. Patient Progress Summary Sheets
12. Peer review reports 9/11/02, 3/6/03, 4/25/03, 5/1/03 and 9/19/03
13. Copies of HCFA 1500 claims

Decision

The Carrier's denial of authorization for the requested services is partially overturned.

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a patient who sustained a work related injury on -----. The ----- chiropractor reviewer also noted that the patient underwent a right carpal tunnel release on 7/10/02 followed by rehabilitation beginning 8/8/02. The ----- chiropractor reviewer further noted that the patient was treated with additional rehabilitation session, medication

and injections. The ----- chiropractor reviewer indicated that the prescribed treatment fulfilled Texas statutory requirements in that it relieved the patient's symptoms and promoted her recovery. The ----- chiropractor reviewer also indicated that the documentation provided did not demonstrate the medical necessity that an evaluation and management service be performed at every routine visit during an already prescribed treatment plan. The ----- chiropractor reviewer further indicated that the range of motion and muscle strength testing services performed on 10/6/03 were not required because a higher-level evaluation and management service (99213) had already been performed on that date. The ----- chiropractor reviewer explained that range of motion and muscle strength testing are a component of an evaluation and that performing them again would have been duplicative and not medically necessary. Therefore, the ----- chiropractor consultant concluded that the range of motion testing (95351) and muscle strength testing (95831) on 10/6/03 and that the office visits (99211) from 9/12/03 through 6/3/04 were not medically necessary to treat this patient's condition. The ----- chiropractor consultant further concluded that the office visits (99213), therapeutic exercises from 9/12/03 through 6/3/04 and that the range of motion testing (95851) and muscle testing (95831) on 9/22/03 were medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department