

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-05-4904.M5**

MDR Tracking Number: M5-05-1233-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 12-17-04.

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, the attended electrical stimulations and the therapeutic exercises from 2-23-04 through 4-19-04 were **found** to be medically necessary. The neuromuscular reeducation and gait training from 2-23-04 through 4-19-04 **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 1-19-05, 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 carrier denied CPT Code 99080-73 on 2-24-04, 3-9-04, 3-23-04 and 4-8-04 with a V for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requestor submitted relevant information to support delivery of service. **Recommend reimbursement of \$60.00.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fee 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 2-23-04 through 4-19-04 as outlined above in this dispute.

This Findings and Decision is hereby issued this 11th day of February 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-1233-01
Name of Patient:	
Name of URA/Payer:	San Antonio Pain Relief Center
Name of Provider: (ER, Hospital, or Other Facility)	San Antonio Pain Relief Center
Name of Physician: (Treating or Requesting)	Michael E. Faber, DC

February 7, 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. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Follow up office notes from referral medical doctor
3. Various copies of completed TWCC-73s
4. Impairment rating and report from treating doctor, dated 05/ /04
5. Office notes from treating doctor, multiple dates
6. Operative notes from ESIs
7. Paper peer reviews, dated 03/01/04 and 03/02/04, from a doctor of chiropractic and a medical doctor, respectively
8. Office notes and lab results from urologist
9. Notes from behavioral pain management specialists (work hardening assessment)
10. Notes from referral orthopedic surgeon
11. Report from required medical evaluation, 04/23/04
12. Functional Capacity Evaluations
13. Pain Management Consultation, dated 01/02/04
14. Request for Reconsideration letter from treating doctor, dated 12/17/04

Patient is a 46-year-old female truck driver who, on ____, was washing her trailer when she slipped on some mud, grabbed the trailer to keep from falling, and injured her lower back. She was seen initially by Concentra, diagnosed with lumbar strain and radiculopathy, and treated with physical therapy and medication. On 11/05/03, a change of treating doctors was approved, and Ms. ____ began with a doctor of chiropractic who immediately ordered an MRI of the lumbar spine. The MRI, dated 11/10/03, revealed mild left central disc protrusion at the

L2-3 level and a central disc protrusion at the L5-S1 level with a suggestion of a small annular tear at same. The doctor of chiropractic eventually referred the patient for a set of three epidural steroid injections which the patient received in the early part of 2004, which was followed by post-injection physical therapy and rehabilitation. The patient was then deemed MMI by the treating doctor in May of 2004 with a 5% whole person impairment. Other than a brief return to work trial in June of 2004 that failed, the patient has not worked since the injury.

REQUESTED SERVICE(S)

Item(s) and Date(s) in Dispute: Office visits (Evaluation and Management services, levels I and III, reported as 99211 and 99213), electrical stimulation, attended (97032), neuromuscular reeducation (97112), therapeutic exercises (97110), and gait training (97116) for dates of service 02/23/04 through 04/19/04.

DECISION

The office visits (99211 and 99213), the attended electrical stimulations (97032), and the therapeutic exercises (97110) are all approved.

All remaining services and procedures are denied.

RATIONALE/BASIS FOR DECISION

In this case, the records adequately established that a compensable injury to the lower back occurred and that the patient received a series of injections for treatment. It was medically necessary, therefore, for the patient to receive appropriate post-injection physical therapy and rehabilitation.

In regard to the neuromuscular reeducation services (97112), there was nothing in either the diagnosis or the physical examination findings on this patient that demonstrated the type of neuropathology that would necessitate the application of this service. According to a Medicare Medical Policy Bulletin¹, "This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Neuromuscular reeducation may be reasonable and necessary for impairments which affect the body's

¹ HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity). The documentation in the medical records must clearly identify the need for these treatments." In this case, the documentation failed to fulfill these requirements, rendering the performance of this service medically unnecessary.

Also, insofar as the gait training services (97116) were concerned, the medical records were devoid of any reference to gait disturbances in either the initial examination dated 11/13/03 or in the subsequent follow up office notes that would otherwise support the application of this procedure. Therefore, the medical necessity of this service cannot be supported.