

MDR Tracking Number: M5-05-1435-01

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 1-13-05.

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.

The therapeutic exercises on 3-3-04 **were found** to be medically necessary. The neuromuscular stimulator, office visits and electrical stimulation-unattended from 1-14-04 through 3-3-04 **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 2-01-05, 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.

CPT code 99213 for date of service 1-16-04 was denied as "N" – "Documentation of OV to support need for OV 2 days after initial extensive OV was performed not submitted." Ingenix Encoder Pro tells us that CPT code 99213 "requires least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity." Review of the office notes submitted reveals that the service rendered does not meet the documentation criteria set forth by the CPT Code descriptor for CPT code 99213. **Recommend no reimbursement.**

CPT code G0283 for date of service 1-30-04 was denied as "F" – "Payment is reduced from the billed amount in accordance with TWCC fee guidelines maximum allowable reimbursement." The EOB shows that the carrier did reimburse the requestor \$13.41. This is the MAR according to TrailBlazer Health Enterprises. **Recommend no additional reimbursement.**

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 totaling \$68.92 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or 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 date of service 3-3-04 as outlined above in this dispute.

This Decision and Order is hereby issued this 17th day of March 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

Enclosure: IRO decision

March 14, 2005

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

Re: Medical Dispute Resolution
MDR #: M5-05-1435-01
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
General Counsel

GP:thh

REVIEWER'S REPORT
M5-05-1435-01

Information Provided for Review:

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

Information provided by Requestor:

- Chiropractic evaluations, office notes & treatment log 01/14/04 – 05/11/04
- Rehab log 02/04 04 – 03/10/04
- Orthopedic surgeon office visits & referrals 02/02/04 & 02/24/04
- X-ray 01/20/04

Information provided by Respondent:

- Correspondence
- Designated doctor exams

Clinical History:

Patient underwent physical medicine treatments after injuring his right knee in a slip and fall on ___ while in the course of his employment.

Disputed Services:

Neuromuscular stimulator, office visits, therapeutic exercises and electrical stimulation-unattended during the period of 01/14/04 thru 03/03/04.

Decision:

The reviewer partially agrees with the determination of the insurance carrier as follows:

Medically necessary:

- Therapeutic exercises on 03/03/04

Not medically necessary:

- All other treatments, office visits, modalities and medical equipment in dispute

Rationale:

Based on the medical records submitted and the patient's positive response to active care, the therapeutic exercises (97110) on 03/03/04 are approved. All other treatments, office visits, modalities and medical equipment are denied.

While combination interferential-muscle stimulation units have been shown to relieve chronic pain, reduce muscle spasm, prevent disuse muscle atrophy, increase local blood circulation and help increase ranges of motion,¹ the records submitted fail to support its medical necessity within the first week of treatment. Moreover, the medical necessity of the unit is not supported due to the fact that the provider was performing electrical muscle stimulation concurrently.

Based on CPT², there is no support for the medical necessity for this high level of E/M service (99213) during an established treatment plan.

It is the position of the Texas Chiropractic Association³ that it is beneficial to proceed to the rehabilitation phase as rapidly as possible, and to minimize dependency upon passive forms of treatment/care since studies have shown a clear relationship between prolonged restricted activity and the risk of failure in returning to pre-injury status. The TCA Guidelines also state that repeated use of acute care measures generally fosters chronicity, physician dependence and over-utilization and the repeated use of passive treatment/care tends to promote physician dependence and chronicity. Therefore, the medical necessity for the electrical muscle stimulation treatment performed on 03/03/04 is not supported.

¹ Glaser, JA, et al. Electrical Muscle Stimulation as an Adjunct to Exercise Therapy in the Treatment of Non-acute Low Back Pain: A Randomized Trial. *Journal of Pain* 2001; 2: 295-300

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

³ Quality Assurance Guidelines, Texas Chiropractic Association.