

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 01-26-05.

The IRO reviewed office visits, manual therapy technique, electrical stimulation, therapeutic exercises and ultrasound rendered from 01-26-04 through 09-13-04 that were denied based upon "V".

The IRO determined that the office visit on 07-07-04, manual therapy technique, therapeutic exercises and ultrasound for dates of service 07-07-04 through 08-04-04 **were** medically necessary. The IRO further determined that the manual therapy technique, therapeutic exercises and ultrasound for dates of service 01-26-04 through 07-06-04 and 08-05-04 through 09-13-04, and the electrical stimulation for dates of service 01-26-04 through 09-13-04 as well as office visits (with the exception of date of service 07-07-04) **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$2,039.19**.

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. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 \$2,039.19 in accordance with the 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 Order is applicable to dates of service 07-07-04 through 08-04-04 in this dispute.

This Findings and Decision and Order are hereby issued this 23rd day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

May 18, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-05-1557-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 42 year-old female injured her low back and left arm on ___ when she slipped on a wet floor. She tried to break her fall with her left arm. She has been treated with medications, therapy, epidural steroid injections and surgery.

Requested Service(s)

Office visit, manual therapy technique, electrical stimulation, therapeutic exercises, ultrasound for dates of service 01/26/04 through 09/13/04

Decision

It is determined the only office visit that is medically necessary is on 07/07/04. All other office visits during the time period in question were not medical necessity to treat this patient's medical condition.

It is determined that there is medical necessity for manual therapy technique, therapeutic exercises, and ultrasound for dates of service 07/07/04 through 08/04/04. There is no medical necessity for these services for dates of service 01/26/04 through 07/06/04 and 08/05/04 through 09/13/04 to treat this patient's medical condition.

It is determined that there is no medical necessity for the electrical stimulation for dates of service 01/26/04 through 09/13/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates an office visit on each date of service in question. There is no medical necessity for an office visit during every visit of an established treatment plan. Only the office visit at the start of established treatment plan on 07/07/04 was medically necessary.

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. Four weeks of post surgical rehabilitation from 07/07/04 through 08/04/04 is a reasonable and generally accepted time period for recovery. Therefore,

the manual therapy technique, therapeutic exercises, and ultrasound for these dates of service are medically necessary.

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, the medical record documentation indicates the patient obtained no relief from the treatments, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to employment. Statutory requirements¹ for medical necessity were not met; therefore, the manual therapy technique, electrical stimulation, therapeutic exercises, and ultrasound for dates of service 01/26/04 through 07/06/04 and 08/05/04 through 09/13/04 were not medically necessary to treat this patient's medical condition.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." in a cursive style.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn

Attachment

¹ Texas Labor Code 408.021

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-1557-01

Information Submitted by Requestor:

- Progress Notes
- Functional capacity evaluation
- Procedures
- Maximum Medical Impairment
- Daily Notes

Information Submitted by Respondent:

- Progress Notes
- Maximum Medical Impairment
- Impairment Rating
- Peer Review
- Procedures
- Diagnostic Tests
- Daily Treatment Notes
- Medical Documentation from 2003 and 2002
- Claims/Miscellaneous