

MDT Tracking M5-05-1688-01

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. This dispute was received on 2-14-05.

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 10-21-03 through 2-12-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, therapeutic exercises, neuromuscular reeducation and manual therapy from 4-26-04 through 9-10-04 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved.

On 3-9-05, 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.

Regarding CPT code 99212 on 5-26-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$48.03.**

The carrier denied CPT Code 99080-73 on 9-09-04 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 \$15.00.**

Regarding CPT codes E0745, 99071, 97032 and 97535 on 9-12-03 and CPT code E0745 on 10-13-04: Neither the carrier nor the requestor provided EOB's. Per Rule 133.307 (e)(2)(A) the requestor must submit a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with 133.304. **Recommend no 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 \$63.03 from 5-26-04 through 9-09-04 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 Decision and Order is hereby issued this 21st day of April, 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

Parker Healthcare Management Organization, Inc.
3719 North Belt Line Road, Irving, TX 75038
972.906.0603 972.255.9712 (fax)

April 6, 2005

ATTN: Program Administrator
Texas Workers Compensation Commission
Medical Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-05-1688-01
RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 3.8.05.
- Telephone request for provider records made on 3.10.05.
- The case was assigned to a reviewer on 3.22.05.
- The reviewer rendered a determination on 4.4.05.
- The Notice of Determination was sent on 4.6.05.

The findings of the independent review are as follows:

Summary of Clinical History

The aforementioned patient was injured as a result of a work related injury on the date of _____. It is documented that the patient was backing up with a metal cabinet when he fell backwards, sustaining injuries to the right shoulder as well as the area of the chest on the left. It appears that the greatest aspect of injury is to the right shoulder. There is also mention of cervical spine pain radiating into the right shoulder with involvement of the right upper extremity. There is also mention of lumbar spine pathology as well. A list of collective diagnoses include Cervical strain, right shoulder contusion, Right hand De Quervain's tenosynovitis, Lumbar muscle spasm, cervical muscle spasm, Multilevel lumbar disc herniation and Partial thickness rotator cuff tear of the right shoulder,

Since the time of the injury, the patient has received multiple medical consults, MRI's, range of motion studies, orthopedic examinations and rehabilitative and therapeutic procedures. All of this documentation has been taken into consideration, in regards to determining the outcome of the clinical questions to be resolved.

Questions for Review

The carrier is disputing the medical necessity of office visits (99212), therapeutic exercise (97110), neuromuscular re-education (97112) and manual therapy (97140). The denial of this care is explained with a "V" code demonstrating a lack of necessity due to peer review. The disputed dates of service are

from 4-26-04 to 9-10-04. That time period is comprised of a multitude of daily visits along with various services provided from the aforementioned list.

Determination

The aforementioned care is reasonable up until the date of March 30, 2004. Care beyond that point is not supported as medically necessary.

Clinical Rationale

The patient initially received active and passive care from Concentra for a brief time period. The patient then received extensive rehabilitative care lasting several months. On November 18, 2003 the patient received an epidural steroid injection. Post injection therapy lasted through December 23, 2003. The patient then received another epidural injection on December 23, 2003 and received post injection care through the date of January 27, 2004. The patient received their third injection on January 27, 2004 and received post injection care through March 30, 2004. Care apparently continued and was ongoing through 9-10-04, approximately 6 months beyond the date of the last injection.

The treating doctor refers to literature from Spine 2002 that reveals spinal injections have a longer duration effect when combined with structural rehabilitation. I agree with this statement based upon the aforementioned literature and my own clinical rehabilitation experience. The injections with rehabilitation, especially active care, seems to help the patient perform with more comfort and be more dynamic in regards to movement.

What is essentially in question here is the time frame that is reasonable for post injection therapy. I agree that two to four weeks of post injection therapy at two to three times per week is reasonable. It appears that this protocol was followed throughout the course of the injections.

Care until the date of March 30, 2004 would be reasonable. This would allow for the continuation of approximately 4 weeks of post injection rehabilitation therapy as done with the two previous sets of injections. Care beyond this is not supported because the patient had a sufficient course of pre-injection rehabilitation therapy, as well as appropriate rehabilitation during the course of the injections.

Therapy beyond the referenced end date does not demonstrate any objective changes in regards to patient improvement. The daily notes from Dr. Schwartz does not demonstrate that the extra 6 months of post injection care beyond March 30, 2004 provided any clear objective changes in range of motion or strength.

Additionally, there are no visual analog or pain scales on the daily notes demonstrating pain levels as being improved. Also absent is subjective or objective documentation that demonstrates the ongoing care was significantly beneficial for the patient. The daily notes in the subjective section only note what the patient's complaints were on that date. There was no mention of any change in the patient's complaints as being better, worse or the same.

The objective section only listed the therapies that were performed; there was no clear objective outcome assessment that would support long term and extensive rehabilitation outside the standards of care as being effective. There was no other clinical documentation to support care after this date, based upon the documents included for review of the case.

Clinical Criteria, Utilization Guidelines or other material referenced

Occupational Medicine Practice Guidelines, Second Edition.

The Medical Disability Advisor, Presley Reed MD
A Doctors Guide to Record Keeping, Utilization Management and Review, Gregg Fisher

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is a diplomate of the American Chiropractic Neurology Board, and serves as an Associate Professor with the Carrick Institute. The reviewer has added credentials in clinical nutrition, rehabilitation and electrodiagnostic medicine. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

In accordance with TWCC Rule 102.4 (h), a copy of this decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 6th day of April, 2005.

If our organization can be of any further assistance, please feel free to contact me.

Sincerely,

Meredith Thomas
Administrator

CC: Horizon Health c/o Bose Consulting
Attn: Juanita Lopez
Fax: 713.690.1508

Liberty Mutual Fire Insurance
Attn: Melissa Rodriguez
Fax: 512.231.0210

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