

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 03-23-05.

Per Rule 133.308(e)(1) date of service 03-22-04 was not timely filed, therefore, is not eligible for review.

The IRO reviewed electrical stimulation, cold pack, manual therapy technique, neuromuscular re-education, therapeutic activities, unlisted special service, office visit, dressing/supplies/material, physical therapy re-evaluation, heat pad, range of motion measurement, physical performance test, therapeutic exercises, mechanical traction therapy and massage therapy rendered from 03-23-04 through 01-26-05 that were denied based upon "V".

The IRO determined that office visits not to exceed one visit per week, neuromuscular re-education total of 2 units, therapeutic activities not to exceed 49 units and physical performance evaluation rendered through 05-19-04 **were** medically necessary. The IRO agreed with the carrier that the remainder of the services and office visits in excess of one visit per week **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 **\$2,098.78**.

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 not the only issue** 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 04-28-05, 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.

CPT code 99080-73 dates of service 04-19-04, 07-27-04 and 09-29-04 denied with a "V" for unnecessary medical treatment based on a peer review. The TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$45.00**. A Compliance and Practices referral will be made as the carrier is in violation of Rule 129.5.

Review of CPT code 99213 on dates of service 12-01-04, 12-10-04 and 01-26-05 and code 99080-73 date of service 01-26-05 revealed that neither party had submitted copies of EOBs. Per Rule 133.307(e)(2)(A) the requestor did not submit a copy of the medical bill(s) to the respondent for reconsideration. No reimbursement is recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees for dates of service 03-24-04 through 09-29-04 totaling \$2,143.78 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 Findings and Decision and Order are hereby issued this 8th day of June 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
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NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION

Original Date: June 3, 2005

Amended Date: June 6, 2005

To The Attention Of:

TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:

MDR Tracking #: M5-05-2057-01

IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed 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 Chiropractic reviewer who has an ADL certification. The reviewer 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Medical records of Dr. Weeks date inclusive 3/22/04 through 5/5/05
- EOBs for services provided from 3/22/04 through 12/20/04
- HCFA forms for services provided from 3/22/04 through 12/20/04
- Medical records of Dr. Port dates inclusive 12/18/03 through 5/28/04
- Medical records of Dr. Payne dated 2/25/04
- Medical records of Dr. Shade dated 4/6/04 and 4/12/04
- Medical records of Rhonda Panksley, LPT dated 4/19/04 and 5/21/04
- Medical records of Kevin Orsado, Ph.D. dated 5/19/04

Submitted by Respondent:

- Medical records of Dr. Weeks dated 11/12/04
- Correspondence from Harris and Harris Attorneys at Law dated 5/10/05
- Medical records of Dr. Payne dated 2/25/04

Clinical History

The claimant is a 63 year old female employee of the _____. According to the medical, the claimant sustained an injury as a result of a fall down a flight of stairs on _____. The claimant had an extensive amount of conservative care as well as surgical intervention. Most notably, she underwent arthroscopy of the right knee on 8/1/02. A second procedure was performed on 2/11/04. The operative procedure involved arthroscopic chondroplasty. Dr. Port was the attending for the surgical procedure. Post operative rehabilitation was ordered by Dr. Port in March 2004. Post operative rehabilitation falls under the auspices of Dr. Weeks, chiropractor. The claimant underwent a designated doctor evaluation with Dr. Shade, M.D. on 4/12/04. Dr. Shade found the claimant had not reached MMI and felt that additional post surgical rehabilitation is needed. An anticipated MMI date of 6/1/04 was assigned.

Requested Service(s)

G0283 electrical stimulation, 97039-CP cold pack, 97140 manual therapy technique, 97112 neuromuscular re-education, 97530 therapeutic activities, 99199-479 unlisted special service, 99213 office visit, 99070 DR dressing/supplies/material, 97002 physical therapy re-evaluation, 97039-HP heat pad, 95851 range of motion measurement - each, 97750 physical performance test, 97110 therapeutic exercises, 97012 mechanical traction therapy, and 97124 massage therapy for dates of service 3/23/04 to 1/26/05

Decision

I disagree with the carrier in part in their decision that chiropractic services rendered from 3/23/04 through 1/26/05 were not medically reasonable or necessary. The following chiropractic services are considered reasonable through 5/19/04: office visits (99213) not to exceed ONE visit per week (for 8 weeks), neuromuscular re-education (97112) for a total of 2 units, therapeutic activities (97530) not to exceed 49 units, and the physical performance evaluation (97750) for date of service 5/19/04. I agree with the carrier that the remainder of the services and the office visits in excess of one visit/week are not medically necessary.

Rationale/Basis for Decision

According to the medical, the claimant underwent arthroscopic chondroplasty of the right knee on 2/11/04. The attending physician for the surgery was Dr. Port. Dr. Port released the claimant to begin post operative rehabilitation in mid-March 2004. Obviously, post operative rehabilitation is indicated for the surgical procedure performed. However, this claimant had had an extensive amount of active care as a result of her work related injury to include post operative rehabilitation for arthroscopy of the right knee in the latter part of 2002. Therefore, and taking into consideration the opinion of Dr. Shade, designated doctor, I feel the following services were reasonable and necessary through 5/19/04. Office visits (99213) not to exceed one visit per week (for 8 weeks), neuromuscular re-education (97112) for a total of 2 units, therapeutic activities (97530) not to exceed 49 units, and the physical performance evaluation (97750) for date of service 5/19/04. As noted, this claimant has had an extensive amount of post operative rehabilitation to include a course of care following the initial arthroscopy. The literature is very clear on the utilization of passive modalities in a chronic musculoskeletal condition. I failed to note the medical necessity for passive modalities in this claimant's chronic knee pain. Therefore, all passive modalities are found to be medically unnecessary. The utilization of manual therapy is unsubstantiated by the documentation provided for my review. Manual therapy is also considered to be passive therapy and is therefore disallowed. This claimant's active rehabilitation of the knee did require therapeutic activities. I would therefore approve the above number units so as to accomplish the goals of post operative rehabilitation. The physical performance evaluation of 5/19/04 is not unreasonable as it was performed at the conclusion of a rehabilitation program. All services after 5/19/04 are found to be unnecessary. All of the testing, whether clinical or computer generated, appears unreasonable and unnecessary.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 6th day of June 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder