

MDR Tracking #M5-05-2097-01

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, 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 03-28-05.

The IRO reviewed established office visits, level III (99213), manual therapy technique (97140-59), therapeutic exercises (97110), ultrasound (97035), paraffin bath (97018), OT re-evaluation (97004), neuromuscular re-education (97112) and physical performance testing (97750-VR) rendered from 04-01-04 through 07-21-04 that were denied based upon "V".

The IRO determined that the established office visits, level III (99213) and the physical performance testing (97750-VR) **were** medically necessary. The IRO further determined that all remaining services and procedures in dispute **were not** medically necessary. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$220.24**.

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.

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 04-27-05, 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 date of service 07-21-04 denied with denial code "V" (based on peer review further treatment is not recommended). Per Rule 129.5 the TWCC-73 is a required report and not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$15.00**. A Compliance and Practices referral will be made as the carrier is in violation of Rule 129.5.

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 06-03-04, 06-18-04 and 07-21-04 totaling \$235.24 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 12th day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

| | |
|--|----------------------------------|
| TWCC Case Number: | |
| MDR Tracking Number: | M5-05-2097-01 |
| Name of Patient: | _____ |
| Name of URA/Payer: | Neuromuscular Institute of Texas |
| Name of Provider: (ER, Hospital, or Other Facility) | Neuromuscular Institute of Texas |
| Name of Physician: (Treating or Requesting) | Brad Burdin, DC |

May 9, 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. Statement of Requestor's position, dated 4/27/05
3. Initial examination and narrative from the treating doctor, dated ____
4. Treating doctor narrative daily notes, from 1/31/03 through 11/26/03, and then again from 2/16/04 through 7/21/04, and 3/1/05
5. "Daily Treatment Logs" from the treating doctor from 2/19/04 through 5/26/04, and again from 3/1/05 through 4/11/05
6. Occupational therapy evaluations, dated 2/18/04, 3/22/04, 4/23/04 and 6/3/04

7. Orthopedic surgeon's follow-up daily notes, dated 1/16/03 through 6/17/04
8. EMG/NCV report, dated 10/28/03
9. Psychophysiological stress profile and biofeedback treatment plan, dated 3/31/03
10. Biofeedback session reports, dated 4/14/03 through 6/23/04
11. Physical performance testing, dated 6/16/04
12. Referral pain management notes, dated 3/22/05
13. TWCC-73s, various dates

Patient is a 48-year-old _____ employee who, on _____, began experiencing pain in her bilateral upper extremities. She presented herself for conservative chiropractic care and began physical therapy and rehabilitation. She eventually underwent Guyon's canal release surgery on 12/31/03 (or on 1/28/04, the records conflict on the date of this procedure), and began post-operative physical therapy and rehabilitation on 2/16/04 for 12 sessions. On 3/15/04, the treating doctor reevaluated her and referred her for 12 more sessions. The surgeon reevaluated the patient on 4/22/04 and recommended more therapy.

REQUESTED SERVICE(S)

Established patient office visits, level III (99213), manual therapy technique (97140-59), therapeutic exercises (97110), ultrasound (97035), paraffin bath (97018), OT reevaluation (97004), neuromuscular reeducation (97112), and physical performance testing (97750-VR) for dates of service 4/1/04 through 7/21/04.

DECISION

The established patient office visits, level III (99213) are approved, and the physical performance testing (97750-VR) is approved.

All remaining services and procedures are denied.

RATIONALE/BASIS FOR DECISION

It was both reasonable and appropriate in this case for the treating doctor to perform periodic assessments of the injured worker in this case, so the medical necessity of these progress examinations was supported. In addition, the physical performance testing on 6/18/04 for purposes of determining the patient's return-to-work status was also appropriate.

However, therapeutic exercises (97110) may be performed in a clinic one-on-one, in a clinic in a group, at a gym or at home, with the least costly of these options being a home program. A home exercise program is also preferable because the patient can perform them on a daily basis. In this case, the provider failed to establish why the continuing services were required to be performed one-on-one, particularly when current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises."¹ In addition, after nearly five years of monitored instruction, the claimant should have certainly been able to safely perform the exercises for her wrists and upper extremities on her own, and if not, the records should have clearly documented *why* not. Any gains obtained in this time period would have likely been achieved through performance of a home program.

In reference to the manual therapy techniques (97140), it is unclear precisely what was performed under the umbrella of services represented by this code. According to CPT², this service might represent manual traction, joint mobilization, myofascial release, or a number of other services. Therefore, it is incumbent upon the provider to specify which specific service was performed when this code is reported. Since the records were devoid of any mention of the particular service that was provided on any of the various dates of service that 97140 appeared, its medical necessity is not supported.

Insofar as both ultrasound (97035) and paraffin baths (97018) were concerned, it is the position of the Texas Chiropractic Association³ that it is beneficial to proceed to the rehabilitation phase (when warranted) 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

¹ Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. *Spine*. 2003 Feb 1;28(3):209-18.

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

³ Quality Assurance Guidelines, Texas Chiropractic Association.

passive treatment/care tends to promote physician dependence and chronicity. Since the records did not document flare-ups (or other extenuating circumstances) on the dates of service these procedures were reported, their medical necessity was not supported.

And finally, with 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 Bulletin⁴, "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 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.

⁴ HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)