

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 4-5-05.

The IRO reviewed therapeutic activities, electrical stimulation, manual therapy techniques, massage, and neuromuscular reeducation for 5-5-04 through 1-19-05 that were denied by the insurance carrier for medical necessity.

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 therapeutic activities, electrical stimulation, manual therapy techniques, massage, and neuromuscular reeducation for 5-5-04 through 1-19-05 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 4-28-05 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 95900 and 95900-76 on 5-14-04 (4 units) and 5-17-04 (4 units) were denied as "Preauthorization was required, but not requested." In accordance with Rule 134.600 (h) (8) only "repeat individual diagnostic study with a fee established in the current Medical Fee Guideline of greater than \$350.00" requires preauthorization. These fees were not greater than \$350.00.

Recommend reimbursement of \$534.72 for 8 units.

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 \$534.72 for 5-14-04 and 5-17-04 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 31st day of May, 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

May 27, 2005

TEXAS WORKERS COMP. COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ___

EMPLOYEE: ___

POLICY: M5-05-2177-01

CLIENT TRACKING NUMBER: M5-05-2177-01/5278

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIOA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIOA for independent review.

Records Received:

Received from the State:

- Notification of IRO assignment, 4/28/05
- TWCC MR-117 Form
- Medical Dispute Resolution Request/Response Form, 4/5/05
- Table of Disputed Services, 5 pages
- Explanation of Benefits, 38 pages

Records from Respondent:

- TWCC MR-117 Form
- Preliminary Physical Therapy Review, Richard A. Silva, M.D., 6/18/04

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- Provider's diagnostic/therapeutic/progress Notes, 1/16/04 to 5/18/04
- FCE, William Novelli, M.D., 6/1/04
- TWCC-69 Report of Medical Evaluation
- Designated Doctor Report, William Greene, M.D., 3/18/04, 9/9/04
- Sensory Nerve Conduction Threshold (CPT) Testing, 1/21/04, 1/22/04, 5/20/04, 5/25/04
- Upper extremity nerve conduction studies, 1/16/04, 5/12/04, 5/14/04, 5/17/04
- Lower extremity nerve conduction studies, 1/19/04, 3/4/04

Records from Requestor:

- Letter from Jo Meek, Health & Medical Practice Associates, 5/2/05
- Copies of pages from TWCC Rules and Texas Worker's Compensation Act, 9 pages
- Chart notes, 5/3/04 - 1/21/05
- Patient Daily Notes report, William Novelli, MD, 5/5/04 - 1/21/05
- FCE, William Novelli, M.D., 6/1/04
- Initial Report, William Novelli, M.D., 1/7/04
- Supplemental Evaluation, William Novelli, MD, 5/13/04
- TWCC-69 Report of Medical Evaluation, 9/14/04, 3/25/04
- Designated Doctor Report, William Greene, M.D., 3/18/04, 9/9/04
- Notice from TWCC to William Green, MD, of Designated Doctor Examination
- Patient registration form, 3/18/04
- Medical Progress notes, 1/21/04 - 12/13/04
- Sensory Nerve Conduction Threshold (CPT) Testing, 1/21/04, 1/22/04, 5/20/04, 5/25/04
- Upper extremity nerve conduction studies, 1/16/04, 5/12/04, 5/14/04, 5/17/04
- Lower extremity nerve conduction studies, 1/19/04, 3/4/04
- Consultation, Nestor Cruz, MD, 7/12/04
- Referral Forms, Health & Medical Practice Associates, 2 pages
- Pre-Certification request, William Novelli, MD, 10/13/04
- Operative Report, Lumbar, Right L5-S1, Transforaminal ESI, Nestor Cruz, M.D., 1/10/05
- Patient Request for Medical Records and X-Ray Reports, 1/8/04
- Medical Records, Saint Elizabeth Hospital ER visit, 1/5/04
- Basic metabolic panel, hemoglobin/hematocrit, urinary analysis with culture and sensitivity, Saint Elizabeth Hospital, 1/5/04
- Letters to Dr. Novelli, 8/18/04, 10/25/04, 12/28/04

Summary of Treatment/Case History:

The patient is a 29 year-old male who suffered a work-related injury to his neck, lower back, both shoulders, right arm, hips, right leg and knee, and headaches on _____. He apparently suffered the injuries while working as a welder when he hit a heavy scaffold. According to the medical records available at the time of this report, CT scan of the brain without contrast revealed no acute intracranial abnormalities. X-rays of the cervical, lumbar spine, bilateral femur and pelvis showed no evidence of fracture or other abnormalities. Multiple upper and lower extremity nerve conduction studies revealed findings suggestive of multiple nerve root involvement and both the cervical and lumbar spine. Patient underwent physical therapy from about 1/8/04 to 1/19/05. Patient had an FCE performed 6/1/04

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which physician felt that patient was at a sedentary work level. On 9/9/04 a designated doctor exam was performed in which physician felt that the patient was not at maximum medical improvement. On 1/10/05 he underwent a transforaminal, L5-S1 lumbar epidural steroid injection by Nestor Cruz, M.D. On 6/18/04 the patient had preliminary physical therapy review done in which 24 treatments from 1/7/04 to 5/5/04 was recommended as medically necessary. It the therapy dates of service from 5/5/04 to 1/19/05 that are apparently in dispute.

Questions for Review:

1. Are the CPT codes, #97530 (therapeutic activities), #97032 (electrical stimulation), #97140 (manual therapy techniques), #97124 (massage therapy), and #97112 (neuromuscular re-education) for dates of services from 5/5/04 to 1/19/05 medically necessary? (Denied by carrier for medically unnecessary with peer review V codes).

Explanation of Findings:

These codes fall within the category of physical therapy. Patient has multiple musculoskeletal diagnoses that can be effectively treated with physical therapy and modalities within recommended treatment guidelines. According to the Official Disabilities Guidelines, 10th edition, under treatment protocols, the recommended physical therapy protocols for specific diagnosis is as follows: Cervical strain/sprain, 10 visits over 6 weeks; Cervical radiculitis/neuritis, 10 visits over 8 weeks; Shoulder sprain/strain, 9 visits over 8 weeks; Lumbar strain/sprain, 10 visits over 5 weeks; Lumbar radiculitis/neuritis, 9-12 visits over 8 weeks; Knee strain/sprain, 12 visits over 8 weeks; Internal derangement of the knee, 9-12 visits over 8 weeks.

A total of 24 treatments from 1/7/04 to 5/5/04 have already been recommended as medically necessary by a qualified physician performing a preliminary physical therapy review on 6/18/04. This is at least double the maximum treatment protocol for any of the above working diagnosis. Therefore, physical therapy and modalities for the dates of services from 5/5/04 to 1/19/05 would be considered unreasonable and not medically necessary or appropriate utilization of physical therapy services.

Conclusion/Decision to Not Certify:

1. Are the CPT codes, #97530 (therapeutic activities), #97032 (electrical stimulation), #97140 (manual therapy techniques), #97124 (massage therapy), and #97112 (neuromuscular re-education) for dates of services from 5/5/04 to 1/19/05 medically necessary? (Denied by carrier for medically unnecessary with peer review V codes).

CPT codes #97530, #97032, #97140, #97124, and #97112 billed for dates of service of 5/5/04 to 1/19/05 were not medically necessary or appropriate utilization of physical therapy services.

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

Generally accepted guidelines for physical therapy; medical records; Insurance claim forms; medical literature.

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References Used in Support of Decision:

- Official Disability Guidelines, 10th edition, Treatment Protocols.
- ACOEM Guidelines, II. Presenting Complaints, ch. 8, neck and upper back; ch. 9, shoulder; ch. 12, low back; ch. 13 knee.

The physician providing this review is board certified in Physical Medicine & Rehabilitation. The reviewer holds additional certification in Pain Management. The reviewer is also a member of the Physiatric Association of Spine, Sports and Occupational Rehabilitation. The reviewer is active in research and publishing within their field of specialty. The reviewer currently directs a Rehabilitation clinic.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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