MDR Tracking Number: M5-03-1244-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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.

The IRO reviewed the office visits, physical therapy, and special reports rendered from 2-13-02 to 8-14-02 that were denied based upon "U.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the 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 May 15, 2003, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

Services denied without an EOB will be reviewed in accordance with Commission's *Medical Fee Guideline.*

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
2-13-02	97750FC	$200.00	$86.00	F	$100.00/hr	Medicine GR (I)(E)(2)(a)	Documentation to support billed service was not submitted.
3-11-02 3-18-02 **6-12-02**	99213	$48.00	$0.00	F	$48.00	CPT Code Description	
3-1-02	97110	$210.00	$140.00	F	$35.00/15 min		
3-11-02 3-18-02	97110	$140.00	$0.00	F	$35.00/15 min		
5-7-02	97014	$15.00	$0.00	F	$15.00		
6-12-02	97250	$43.00	$0.00	F	$43.00		
5-7-02 6-12-02	97265	$43.00	$0.00	F	$43.00		
8-2-02	97039	$50.00	$0.00	No EOB	DOP		

8-2-02	97110	$175.00	$0.00	No EOB	$35.00/15 min		
TOTAL							The requestor is not entitled to reimbursement.

This Order is hereby issued this 1st day of August 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 23, 2003

RE: MDR Tracking #: M5-03-1244-01
IRO Certificate #: 5242

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

___ 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 physician reviewer. The Chiropractic physician 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.

Clinical History

It appears the claimant suffered a work related injury that involved a complex fracture of several bones of his anterior foot with accompanying nerve damage that occurred on ___ when a forklift rolled over his right foot. The nondisplaced fractures and injuries were appropriately treated by a podiatrist; however, the claimant remained in pain and was felt to have complex regional pain syndrome or reflex sympathetic dystrophy. Repeat electrodiagnostic studies did reveal some evidence of tarsal tunnel syndrome. It was also felt the claimant had a Morton's neuroma involving the third web space of the right foot. Because the claimant fell at the time of the injury, the claimant also suffered alleged right leg and chest bruises and contusions which have long since healed. A tarsal tunnel release surgery and Morton's neurectomy were performed in April 2002 and post operative rehabilitation was begun on or about 4/30/02 under the direction of a chiropractor. The claimant has been told by a podiatrist, and an orthopedic foot specialist, that further treatment and surgery would not likely progress his condition and further invasive treatment was not indicated. The claimant was examined by an independent medical exam doctor on or about 10/18/02 and was felt to be at maximum medical improvement with 2% whole body impairment rating. The claimant at this time was noted not to be limping. Observation of his feet noted that the feet were symmetrical except for some scar formation of the right foot that was obviously due to surgery. The claimant had a mild Tinel's test at the right medial malleolus that was consistent with medial plantar

nerve involvement. There was no evidence on 10/18/02 that the claimant had reflex sympathetic dystrophy. I fail to see how tarsal tunnel syndrome would even be involved with an injury that involved the anterolateral portion of the right foot. A note from the doctor of June 2002 felt the claimant would have pain mainly due to scar tissue and that no further invasive treatment was needed and that further treatment of any kind would not likely progress this claimant's condition any further than had already been accomplished. It appears the claimant did undergo sympathetic blocks on 2/20/02. Voluminous medical records from many physicians and evaluating providers were reviewed in preparation of this IRO decision. The claimant was recommended to undergo a work hardening program in September 2002. It was revealed on 9/3/02 that the claimant was recently fired from his pre-injury level job. On 9/3/02 a podiatrist, and the surgeon who treated the claimant stated to the claimant that he may be as good as he was going to get. Again, multiple chiropractic notes were reviewed before and after the April 2002 surgery. Most of the treatment was in the form of treadmill, stationary bike and various stretches and active care programs. An occasional ultrasound modality was used and occasional ice or heat and electric stimulation was also utilized. Most of the treatment in question appeared to be of the active variety. According to the treating chiropractor the claimant underwent physical therapy beginning on 4/30/02 and this continued through 8/14/02. It appears that the treating chiropractor was reimbursed approximately 22 times for 22 visits which occurred from 4/30/02 through the re-evaluation of 6/26/02. There were some visits in June, July and August which were not reimbursed due to lack of medical necessity based on several peer reviews.

Requested Service(s)

The medical necessity of outpatient services rendered from 2/13/02 through 8/14/02 to include office visits, physical therapy and special reports.

Decision

I agree with the insurance carrier that the services in dispute were not reasonable or medically necessary.

Rationale/Basis for Decision

The services administered on 3/11/02, 3/13/02, 3/18/02 and 3/20/02 came after exhaustive physical therapy and conservative care had already taken place without objective documentation of improvement. By 3/19/02 or before, the doctor was recommending the claimant undergo surgery. Post operative physical therapy reportedly began on 4/30/02 and the chiropractic provider was reimbursed for about 22 visits through 6/12/02 and for the re-evaluations of 6/26/02 and 7/22/02. The documentation shows the chiropractor was reimbursed for care that was in no way documented to be effective at any time. Post operative treatment for Morton's neuroma and tarsal tunnel syndrome has exceeded the recommendations of the evidence based Official Disability Guidelines 2003 issue. There was no documented evidence of improvement in any of the re-evaluations or in any of the other evaluating physician's reports. Documentation of improvement must go beyond "patient improving with therapy" as was reported multiple times in the chiropractic documentation. The chiropractor is in error if she believes any and all treatment that simply provides pain relief is reasonable and medically necessary as it pertains to a work related injury. This is no excuse for ineffective care that has time and time again shown no evidence that it is progressing the claimant's condition objectively toward a curative state. Also please consider that the theraband activities and various other stretches and treadmill/stationary bike activities that the claimant underwent could have been done at home. As of 6/26/02, the doctor felt that nothing further would likely contribute to progression of this claimant's condition. The doctor also was of similar opinion in October 2002. The claimant was told by the doctor in September 2002 that he was probably as good as he was going to get.

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 23rd day of April 2003.