THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-3602.M5

MDR Tracking Number: M5-03-1580-01

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, 2003 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 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 office visits were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that the office visit fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 4/3/02 through 9/18/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 9th day of May 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

April 25, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #:	M5-03-1580-01
IRO #:	5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor, board certified in family practice and specialized in Occupational Medicine. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___is a 60-year-old woman who sustained a work-related injury while employed as a sales/cashier for ___ on ___. She sustained the injury when she was hanging a dress on the rack, slipped on a grape, fell, hit her head and landed on the right side of her body. No documentation was available immediately after the injury, however, it appears that she was seen at ___ at the time of the injury and then continued her care with ___. She underwent a cervical laminectomy and fusion of the cervical vertebrae in 1994 by ___ an orthopedic surgeon in ___. She also underwent a rotator cuff repair on 10/95.

On 19/5/95, ___ did a psychiatric medical evaluation to determine the causal relationship between psychiatric care and this patient's injury. It was determined that without documentation, that relationship could not be established. On 5/16/96 ___ determined that she had reached MMI and assigned a 19% whole person impairment rating. On 9/17/96 the statement of employment status indicated that she did not make a good faith effort to seek employment within her ability to work. On 10/3/96 ___ reported that she had gone to the emergency room for complaints of pain in her head and neck. On 12/19/96 ___ fired her from his medical practice. On 12/29/96, an investigative report was conducted by ___. On 1/20/97 an FCE was performed at ___ with evidence of significant functional overlay and symptom magnification. On 1/27/97 she changed treating doctors to ___. From 1/29/97 to 2/17/00 the treatment records from ___ show that conservative care continued with oral medications. An MRI scan of the right hip was recommended, though the carrier did not approve the procedure. From 4/15/97 to 4/30/98, the progress notes from ___ show that she was referred to ___ for counseling. On 5/6/98 the follow-up progress note from ___ indicated that she continued complaining of cervical and lumbar tenderness and decreased range of motion secondary to pain. An SEP/NCV of the upper extremities was recommended, and she was advised to continue the oral medications. On 7/9/98 the SEP of the BUE reported evidence consistent of a left carpal tunnel syndrome and evidence suggestive of a bilateral conduction block at Erb's point, perhaps some variation of an upper brachial plexus lesion. A needle EMG of the BUE was suggested. The notes from ___ form 7/9/98 to 3/4/99 show that she continued her oral medications. On 3/30/99 ___, performed a psychological evaluation. He diagnosed her with major depression and generalized anxiety disorder. Pain management for twelve weeks, BFB, individual psychotherapy for depression, group psychotherapy, and physical therapy were recommended, though the carrier did not approve the treatment. The notes from ___ from 3/99 to 2/17/02 show that conservative treatment was continued with Darvocet, Vanadom, Soma, and Limbitrol. The notes from 11/5/01 to 12/3/02 show that ___ was seen for follow-up evaluations in which the diagnoses were cervical radiculopathy and lumbar radiculopathy. The notes state that ___ gave ___ medications, kept her out of work, and saw her roughly at one-month intervals.

DISPUTED SERVICES

Under dispute are office visits from 4/3/02 through 9/18/02.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The office visits in question are also noted to be CPT code of 99214, an established visit, 25 minutes. Review of those progress notes show that on the disputed visits ___ was only given a prescription for her medications. There was no other treatment given.

Review of those visits shows that this patient continued with subjective complaints of tenderness and increased pain. The documentation of the objective findings is scant and the findings are not well documented. As an example, the progress note of 4/3/02 has only two sentences on the interim history and three sentences on the physical examination. The report of 9/18/02 shows the interim history to have only two sentences and the objective findings to have only three sentences. Furthermore, the visit of 9/18/02 states that the objective findings showed that the patient revealed tenderness to palpation, but there is no note of where the tenderness was located. The second sentence shows that the patient complains of continued pain and spasms of the cervical region and the right shoulder and arm, though, as noted by ___, these are complaints by ___ and not actual findings. He does not note the location of the pain or spasms to the cervical region, the right shoulder, and the right arm. There is no other documentation to note whether there is any radiculopathy or neurovascular finding. Furthermore, a patient being seen almost nine to ten years after the date of injury should be on over-the-counter medications, if any at all. The notes document that ___ was only giving ___ medications and providing no other active treatment.

An office visit with CPT code 99214, established patient, 25 minutes, is a code for an office or other outpatient visit for the evaluation and management of an established patient. This requires at least two of three key components: a detailed history, a detailed examination, and medical decision making of moderate complexity. This states that counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problems(s) are of moderate to high severity. Physicians typically spent 25 minutes face-to-face with the patient and/or family.

In summary, ___ progress notes are very poorly documented. They do not justify a visit with a CPT code of 99214. Beyond that, the reviewer finds that ten years after her date of injury, this patient should be on over-the-counter medications at most. There is no justification for the office visits from 4/3/02 through 9/18/02.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,