

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

SOAH DOCKET NO. 453-03-4033.M5

MDR Tracking Number: M5-03-2030-01

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 Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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 the only issue** to be resolved. The office visits dated, 6/12/02, 8/14/02, 8/22/02, 8/26/02, 9/3/02 and FCE on 7/17/02 were found to be medically necessary. The office visits on 7/1/02 and 7/25/02 were found not medically necessary. The respondent raised no other reasons for denying reimbursement for these office visits and FCE charges.

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 in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service through in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 17th day of June 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 6, 2003

RE: MDR Tracking #: M5-03-2030-01

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. 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

The claimant apparently sustained repetitive type injuries on ___ to his neck, shoulder and elbow while working for his employer. Initial treatment was performed by the claimant's supervisor, on the day of the injury and referred to Dr. ___ for chiropractic conservative care thereafter. The claimant was referred to several medical doctors for evaluation and assessment. Pain and anti-inflammatory medications were prescribed as well as a physical therapy program and referral recommendations inclusive of an MRI of the cervical spine, performed on 1/21/02 with findings basically unremarkable and an electromyogram study performed on 5/22/02 which found possible nerve root irritation at C6/C7. Epidural steroid injection and facet injections were performed to the cervical spine on 6/28/02 and 9/06/02 by Dr. ___. A designated doctor exam was performed on 6/18/02 by Dr. ___ who found the claimant to be at maximum medical improvement on that date and assigned a 5% impairment rating whole person. According to documents received for this review, the claimant has continued with chiropractic care on an as needed basis.

Requested Service(s)

Please review and address the medical necessity for the outpatient services rendered from 6/12/02 thru 9/03/02. Were the office visits and test medically necessary?

Decision

I disagree with the insurance carrier and find that office visits dated 6/12/02, 7/17/02, 8/14/02, 8/22/02, 8/26/02 and 9/03/02, including the functional capacity exam are medically necessary. However, I agree with the insurance carrier and find office visits dated 7/01/02 and 7/25/02 not to be medically necessary. Furthermore, I find that the visits coded as 99214 on 6/12/02 and 8/14/02 were incorrectly coded, and should be reimbursed using code 99213.

Rationale/Basis for Decision

While it is agreed that this diagnosis lacks diagnostic severity (i.e. cervical MRI normal, nerve conduction velocity/Electromyogram with possible radiculopathy findings), the circumstances surrounding the case are open for discussion.

Apparently a designated doctor exam was performed on 6/18/02 and found maximum medical improvement to be on that date and a 5% impairment rating was assigned. Even though the report is not available, the 5% impairment rating is at least evidence from an independent source that this claimant apparently still had subjective and objective findings due to the incident on ____.

The claimant is entitled to reasonable and necessary care due to the work related injury, even after maximum medical improvement, if it is necessary. However, this does not mean the treating doctor can treat whenever and however they choose.

Treatment for exacerbation conditions, if well documented, is acceptable treatment initially following return to work status, if necessary, to help maintain that status. According to the available documentation from the treating doctor, it is apparent that treatment was allowing the claimant to remain in return to work status.

The treating doctor does provide supporting documents that treatment for these exacerbation conditions was necessary if the report is accurate (refer to rebuttal note dated 5/15/03 by Dr. ____ and treatment notes; 6/12/02 thru 9/03/02). At least one exacerbation condition was apparently verified by the company supervisor, who was reported to have treated the condition on site and suggested at that time that the claimant seek evaluation with the treating doctor.

Relief care beyond maximum medical improvement is acceptable, according to the TWCC spine treatment guideline, used as a reference. However, it should be minimized and should demonstrate at least 4 criteria to be considered necessary: (1) it should demonstrate a decrease in pain of lasting quality; (2) it should demonstrate a decrease in pain medication; (3) it should demonstrate increased functional abilities, including range of motion and (4) it should help the claimant to retain gainful employment.

The office visits that included treatment appeared to fulfill the above criteria, especially since it was directly following the claimant's return to work, on or about 7/17/02. Before and after range of motion measurements were documented with noted improvement. Accordingly, pain level

decreases were also noted. Documentation also noted that it did help the claimant with return to work status. The accompanying documentation appears supportive for necessity of care in relation to the exacerbation conditions with verification by someone other than the treating doctor. The main goal here is that the claimant maintains a return to work status with the least possible intervention.

Another factor involved in forming my opinion that the claimant was still presenting with periodic exacerbation conditions and thus, in need of relief care, is the fact that epidural steroid injections were delivered on 6/28/02 and again on 9/06/02. It has been my experience that most claimants will not undertake this invasive procedure unless a true pain symptomology occurrence was evident. (A few might in order to delay return to work; however, this does not appear to be the case.)

Concerning the office visits for evaluation purposes only, after maximum medical improvement, these are for the most part not as essential in regards to care beyond maximum medical improvement. Maximum medical improvement has already established that the condition has stabilized and is not expected to change significantly in the next 12 months. Therefore, evaluation should already be conducted and included each time treatment is rendered for an exacerbation occurrence, when dealing with relief care.

Concerning the functional capacity exam testing; if what was reported by the treating doctor is accurate, then this test was reasonable and necessary to satisfy the requirements of the employer and as such is supported. The treating doctor reported that the employer requested this in connection with the claimant's employment status. Pre-authorization should not be required under these circumstances concerning this functional capacity exam and in this situation the rationale appears appropriate for the benefit of both the employer and the claimant.

I did not find anywhere in the dates of service from 6/12/02 thru 9/03/02 that excessive treatment was rendered to this claimant. In order for an office visit to be billed using CPT code 99214, two of three conditions must be met, a detailed history, a detailed physical examination, or medical decision making of moderate complexity. Upon review of the office notes from 6/12/02 to 8/14/02, none of these visits contain elements compatible with two of the three conditions for coding the visit 99214. These are correctly coded as 99213. (Visits after 8/14/02 are coded as 99213.)

Dates accepted as reasonable and necessary are 6/12/02, 7/17/02, 8/14/02, 8/22/02, 8/26/02 and 9/03/02. Dates that are not accepted as reasonable and necessary are 7/01/02 and 7/25/02.

This review is based only on documentation as recorded in the records reviewed. This reviewer is aware of the possibility that certain documentation may not have been available for review.

Therefore, speculations on certain events may have been made in this report conducive to similar cases in general practice regarding standards of care, current research updates, managed care guidelines, case history outcomes, past and current research literature, etc., which were used as a guideline.

It is the sole responsibility of the provider to establish necessity for care by providing supporting documentation and this reviewer cannot be held responsible, if unknowingly to the fact, concerning the lack of documentation renders a decision or opinion based on what is presented.