

MDR Tracking Number: M5-04-0073-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 9-5-03.

The IRO reviewed office visits, myofascial release, and application of modalities, therapeutic activities, and therapeutic procedures from 9-5-02 through 3-3-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the medical necessity issues. The IRO agreed with the previous determination that the joint mobilization and therapeutic activities (97530) were **not** medically necessary. The IRO concluded that the office visits, myofascial release, application of modalities, and therapeutic procedures (97110) were medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. The disputed dates of service 9-3-02 through 9-4-02 are untimely and ineligible for review per TWCC Rule 133.307 (d)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute. The Commission received the medical dispute on 9-5-03.

On 1-21-04, 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 disputed dates of service 9-9-02, 10-7-02, 10-21-02, and 10-23-02 were denied as "D –duplicate". Therefore, this review will be per the 1996 *Medical Fee Guideline*. The requestor did not submit additional documentation to support delivery of services. Therefore, no reimbursement recommended.

The above Findings and Decision is hereby issued this 13th day of February 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

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 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 for dates of service 9-5-02 through 3-3-03 in this dispute.

This Order is hereby issued this 13th day of February 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

January 5, 2004

Amended February 18, 2004

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

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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 Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL).

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

___ hurt her low back when she was working as a custodian for ___ and was lifting trash bags and tossing them into bins. She initially had pain in the low back and this was apparently radicular to the left leg and ankle. EMG indicates a left sided radiculopathy at the level of S1. MRI was significant for a herniation at the level of L5/S1, consistent with the EMG findings. She underwent a series of ESI treatments and was evaluated for surgery, but found not to be a candidate. She underwent extensive physical medicine to include work conditioning and was returned to work by her treating doctor, ___. The patient was examined by ___ who found that no further care was necessary but then stated that “if she continues to have persistent pain despite conservative treatment, additional therapeutic interventions may be necessary in an attempt to improve her condition.”

DISPUTED SERVICES

The carrier has denied the medical necessity of office visits, myofascial release, application of modalities, therapeutic activities, therapeutic procedures and physical performance testing as medically unnecessary with a peer review.

DECISION

The reviewer agrees with the prior adverse determination regarding joint mobilization (97265) and One-on-One Therapeutic procedures (97530)

The reviewer disagrees with the prior determination on all other treatments rendered.

BASIS FOR THE DECISION

The treatment rendered was generally well documented and displayed a treatment program that was appropriate in its attempt to get the patient back to work in the most conservative means possible. The documentation of the physical performance tests was evidence that the patient continued to make progress in her efforts to return to work. Considering the evidence of a radiculopathy along with the MRI indicating a disc herniation that was obviously the agent of the radicular pain, the treating doctor’s program was generally reasonable. Joint mobilization is not documented as being a valid treatment in this case, as manipulation is part of the office visit. There is also no indication that this case required the extensive treatment of one-on-one therapeutic activities. With those exceptions, the reviewer finds that the medical necessity is established.

___ 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,