

MDR Tracking Number: M5-04-1084-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on December 12, 2003. According to the TWCC Rule 133.308 (e) dates of service 9/27/02 through 12/11/02 were received after the one-year filing deadline and therefore are not eligible for review.

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 the office visits with and without manipulation, aquatic therapy, and massage therapy rendered on 12/12/02 through 6/11/03 were not found to be medically necessary and the Division declines to issue an Order in this Dispute. The requestor is not entitled to reimbursement of the IRO fee.

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 March 9, 2004, 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:

| DOS | CPT CODE | Billed | Paid | MAR | EOB Denial Code | Rationale |
|---------|----------|---------|--------|---------|-----------------|---|
| 4/10/03 | 99080-73 | \$15.00 | \$0.00 | \$15.00 | F-TD | Review of the carrier's EOB revealed the CPT code 99080-73 was denied by the carrier with exception code F-TD "The work status report (TWCC 73) was not properly completed or was submitted in excess of the filing requirements, therefore, reimbursement is denied per Rule 129.5." Review of the TWCC 73 for the disputed charges did not document a change in work status or a substantial change in activity restrictions. Therefore reimbursement is not recommended. |
| 5/28/03 | | \$15.00 | \$0.00 | \$15.00 | F-TD | |
| 6/11/03 | | \$15.00 | \$0.00 | \$15.00 | F-TD | |
| TOTAL | | \$45.00 | \$0.00 | \$45.00 | | |

Therefore reimbursement for dates of service from 12/12/02 through 6/11/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 8th day of October 2004.

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

March 4, 2004

Amended March 5, 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

The patient was injured on her job when she slipped on an oiled floor and hit her head on a table, causing immediate pain in the low back. She was initially treated by Dr. N and later changed doctors to Dr. B and then to Dr. C because Dr. B withdrew from the case. MRI of the lumbar spine was negative but she later was sent for a surgical consultation, which recommended that surgery not be performed. The patient was treated with extensive physical medicine over the period of about 2 years. MMI was assessed by Dr. N on December 20, 2001. A designated doctor, Dr. K, found MMI to be on the same date. Both doctors assessed 5% impairment through DRE II of the AMA guides.

DISPUTED SERVICES

The carrier has denied the medical necessity of office visits, office visits with manipulation, aquatic therapy and massage therapy from December 12, 2002 through June 11, 2003.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer finds no documentation that would explain how a sprain/strain of the lumbar spine could be treated so extensively with any success. There is no documentation by the requestor that the care rendered had a positive effect on this patient and there is no reason in this file for the extended length of care. The patient clearly was at MMI long before any of this care was rendered and there is no indication that the condition changed or that the patient became in any way worsened to require such extensive care. As a result, the reviewer finds the care to not be medically necessary.

___ 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,