

MDR TRACKING#: M5-04-1190-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-29-03.

The IRO reviewed office visits, ROM testing, muscle testing, ultrasound, manual therapy, unlisted therapeutic procedure, myofascial release, therapeutic procedure, hot/cold packs, and vasopneumatic device rendered from 1-23-03 to 8-11-03 that were denied based upon “V”.

The IRO concluded that office visits, ROM testing, muscle testing, ultrasound, manual therapy, unlisted therapeutic procedure, myofascial release, therapeutic procedure, hot/cold packs, and vasopneumatic device were not medically necessary from 1-23-03 through 3-13-03 and 5-21-03 through 8-11-03. The IRO concluded that office visits, ROM testing, muscle testing, ultrasound, manual therapy, unlisted therapeutic procedure, myofascial release, therapeutic procedure, hot/cold packs, and vasopneumatic device rendered from 4-17-03 through 5-20-03 were medically necessary.

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

On this basis, the total amount recommended for reimbursement (\$2299.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On April 14, 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:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
5-12-03 5-14-03 5-16-03	97139	\$35.00	\$0.00	N	DOP	General Instructions GR (III)	SOAP notes do not document physical therapy service, no reimbursement is recommended.

This Decision is hereby issued this \_\_\_\_ day of \_\_\_\_\_, 2004

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 Decision is applicable for dates of service 1-23-03 through 8-11-03 in this dispute.

This Order is hereby issued this \_\_\_\_ day of \_\_\_\_\_, 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

March 12, 2004

Texas Workers Compensation Commission  
MS48  
7551 Metro Center Drive, Suite 100  
Austin, Texas 78744-1609

**NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-04-1190-01      Revised**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Southeast Health Services, Inc.**  
**Respondent: Royal and Sun Alliance**

**MAXIMUS Case #: TW04-0052**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

**Clinical History**

This case concerns a 22 year-old female who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work she was driving a van when it hydroplaned on some water and hit the median divider on the freeway. The patient was evaluated in the emergency room and was released. X-Rays of the cervical, lumbar spine and right knee dated 12/9/03 indicated hypolordosis, hypomobility of the cervical spine, hyperlordosis and hypomobility of the lumbar spine, and a high pelvis on the right were the reported results of the right knee x-ray. The initial diagnoses for this patient included lumbar intervertebral disc syndrome, lumbar radiculopathy, sciatica, and facet syndrome. The patient has been treated with oral medications, joint mobilization, electrical stimulation, mechanical traction and hot/cold packs.

**Requested Services**

Office visits, joint mobilization, electrical stimulation, mechanical traction, and hot/cold packs from 1/15/03 through 2/12/03.

**Decision**

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

### **Rationale/Basis for Decision**

The MAXIMUS chiropractor reviewer noted that this case concerns a 22 year-old female who sustained a work related injury to her cervical and lumbar spine, and right knee on \_\_\_\_\_. The MAXIMUS chiropractor reviewer indicated that the patient had been diagnosed with a cervical/thoracic, and lumbar sprain/strain. The MAXIMUS chiropractor reviewer explained that the initial phase of treatment for nonsurgical low back pain can last between 6-12 weeks (North American Spine Society; NASS:2001). The MAXIMUS chiropractor reviewer also explained that the documentation provided indicated that between the dates of service, 1/15/03 and 2/12/03, the patient had continued pain, muscle spasms, and decreased range of motion in the cervical and lumbar spines. The MAXIMUS chiropractor reviewer indicated that using the North American Spine Society Guidelines for lower back pain, the treatments rendered to this patient are within accepted guidelines for treatment of muscle spasm/strain. Therefore, the MAXIMUS chiropractor consultant concluded that the office visits, joint mobilization, electrical stimulation, mechanical traction, and hot/cold packs from 1/15/03 through 2/12/03 were medically necessary to treat this patient's condition.

Sincerely,  
**MAXIMUS**

Elizabeth McDonald  
State Appeals Department