

MDR Tracking Number: M5-04-1631-01

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, 133.307 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 02-05-04.

The Medical Review 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, therapeutic exercises, neuromuscular re-education, therapeutic activities, electrical stimulation, and injection-tendon/ligament/cyst rendered from 5/22/03 through 6/23/03 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 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 May 7, 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.

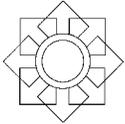
CPT code J0587-the requestor originally submitted the bill for this service in March 2003. Subsequent submissions of bills for this code were resubmitted notating a billing error and the code was changed to J3490. On October 1, 2003, the requestor resubmitted the bill to the carrier for code J0587 for reconsideration and sent a letter to the carrier explaining that the requestor had contacted the pharmaceutical company to verify the correct billing code. Neither the requestor nor the carrier submitted an EOB for code J0587 indicating the basis for denial. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service for CPT code J0587 on date of service 6/23/03. **Reimbursement is recommended** in the amount of \$231.25 for the amount billed in accordance with the 1996 Medical Fee Guidelines.

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 date of service 6/23/03 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 Decision and Order is hereby issued this __4th__ day of October 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
Enclosure: IRO Decision



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

April 22, 2004

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-04-1631-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional 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 TMF 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

This 32 year old female suffered an acute neck and lower back pain after a slip and fall at work on _____. The patient states her intermittent sharp lower back pain is a "4" on a scale from 1 to 10. The plan of care includes therapeutic exercises, neuromuscular re-education, therapeutic activities, office visits, and electrical stimulation, injection-tendon/ligament/cyst.

Requested Service(s)

Office visits, therapeutic exercises, neuromuscular re-education, therapeutic activities, electrical stimulation, and injection-tendon/ligament/cyst from 05/22/03 through 06/23/03.

Decision

Denial of office visits, therapeutic exercises, neuromuscular re-education, therapeutic activities, electrical stimulation, and injection-tendon/ligament/cyst from 05/22/03 through 06/23/03.

Rationale/Basis for Decision

The claimant showed minimal to no organic pathology that would allow classification of her _____ injury outside the strain/sprain therapeutic algorithm. Provider's application of therapies from 05/22/03 through 06/23/03 are simply not warranted from the severity of the recorded injury and from the diagnostic record presented. A 12 session course of conservative Chiropractic/Physical Therapy management over 4-6 weeks duration with progression toward active, patient-driven therapeutics seems appropriate. Supervised clinical management of this claimant's condition beyond 6-weeks is not warranted from the reviewed medical record. Therefore, it is determined that office visits, therapeutic exercises, neuromuscular re-education, therapeutic activities, electrical stimulation, and injection-tendon/ligament/cyst from 05/22/03 through 06/23/03, are not medically necessary.

Sincerely,

A handwritten signature in black ink, appearing to read "Gordon B. Strom, Jr.", written in a cursive style.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm