

MDR Tracking Number: M5-04-1673-01

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 02-09-04.

The IRO reviewed office visits, manual therapy, therapeutic exercises, mechanical traction, neuromuscular re-education, therapeutic activities, hot/cold pack therapy, muscle testing, range of motion measurement and FCE rendered from 09-30-03 through 12-15-03 that were denied based upon "V".

The IRO determined that services from dates of service 09-30-03 through 10-21-03 **were** medically necessary. The IRO determined that dates of service after 10-21-03 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of issues of medical necessity. 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.

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 04-15-04, 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.

CPT code 99080 date of service 10-15-03 denied with denial code 790/F (service reduced in accordance to the Texas Medical Fee Guideline) and 99080-73 date of service 12-02-03 denied as "V" (unnecessary medical treatment based on a peer review). Both services are reviewed as fee issues. Requestor did not submit relevant information to support delivery of service of 99080 date of service 10-15-03. No reimbursement recommended. Code 99080-73 is a TWCC required report and is not subject to an IRO review. The

Medical Review Division has jurisdiction in this matter and therefore, recommends reimbursement in the amount of \$15.00.

### **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 09-30-03 through 12-02-03 in this dispute.

This Findings and Decision and Order are issued this 8<sup>th</sup> day of October 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

April 12, 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 documentation presented states the patient is a 36-year-old Latin-American female who was injured at her job on \_\_\_\_. She was cleaning a bathroom when she slipped and fell onto her buttocks, hitting her coccyx, injuring her left arm and hitting her head against the wall. The patient sought care at \_\_\_\_ on 07/31/03 with Dr. \_\_\_\_\_, who diagnosed her with intervertebral disc disorder with myelopathy, lumbar region, lumbar nerve root compression, cervical disc displacement/herniation, unspecified site of ankle sprain, and sprain of unspecified site of the wrist. This patient also began active and passive care for her work-related injury at a frequency of 5x per week for the first two weeks.

\_\_\_\_ was referred for a lumbar MRI on 08/29/03 that revealed a 2 mm symmetrical annular disc bulge and a L5/S1 focal posterior central discal substance herniation. The patient did undergo a designated doctor's exam on 10/21/03 that stated the patient was at MMI on 10/21/03 with a 0% whole person impairment rating. The designated doctor also noted no functional range of motion loss or neurological loss in any of the areas injured.

### DISPUTED SERVICES

Under dispute is the medical necessity of office visits, manual therapy, therapeutic exercises, mechanical traction, neuromuscular re-education, therapeutic activities, hot/cold pack therapy, muscle testing, range of motion measurement and FCE provided from 09/30/03 – 12/15/03.

### DECISION

The reviewer disagrees with the prior adverse determination for dates of service through 10/21/03, but agrees with the prior adverse determination for dates of service beyond that date.

### BASIS FOR THE DECISION

The \_\_\_ reviewer agrees with the medical necessity of treatment and services provided up to 10/21/03, at which time the designated doctor actively examined this patient. The treatment would be considered medically necessary based on documentation provided that displays the patient having functional deficits that were responding well to treatment. The patient was then examined by a designated doctor who documented no objective findings that would support continued treatment for this patient at this level and intensity. The patient could have been assessed a home program at that time. The patient's

objective findings were also taken into account in this IRO that did not support the need for continued care up to five months post injury for such minimal pathology, based on current guidelines.

\_\_\_ 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,