

MDR Tracking Number: M5-04-1903-01

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 02-26-04.

The IRO reviewed neuromuscular shock unit, durable medical equipment, office visits, therapeutic exercises, unusual travel, hot/cold pack therapy, electrical stimulation unattended, myofascial release, ultrasound therapy, mechanical traction rendered from 05-21-03 through 09-12-03 that were denied based upon "V".

The IRO determined that the unusual travel and purchase of a nerve stimulator rendered from 05-21-03 through 09-12-03 **were not** medically necessary. The IRO concluded that the durable medical equipment, office visits, therapeutic exercises, hot/cold pack therapy, electrical stimulation unattended, myofascial release, ultrasound therapy and mechanical traction rendered from 05-21-03 through 09-12-03 **were** medically necessary. The respondent raised no other reasons for denying reimbursement for the services listed above.

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 05-25-04, 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 99080-73 dates of service 05-22-03, 07-28-03, 07-31-03 and 09-12-03 denied with a "V" denial code. The TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction. Reimbursement in the amount of \$60.00 (\$15.00 times four (4) dates of service) is recommended.

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 05-21-03 through 09-12-03 in this dispute.

This Findings and Decision and Order are hereby issued this 7th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

May 12, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1903-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ 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 ___ for independent review in accordance with this Rule.

___ 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 ___ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ 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 ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ___. The patient reported that while at work he injured his low back when he attempted to grab a falling piece of sheetrock. The patient underwent x-rays of the lumbar spine on 3/14/03 and a MRI scan of the lumbar spine on 4/15/03. A CT scan of the lumbar spine dated 4/23/03 indicated multilevel Schmorl nodes present, exaggerated lordosis, steep angulation to the sacrum, bilateral spondylolysis at L5, and slight narrowing of the central canal at L5-S1. The patient underwent a

fluoroscopically guided lumbar L4-5 epidural steroid injection and lumbar epidurogram for the diagnoses of low back pain and lumbar radiculitis. Following the injection the patient was evaluated on 5/13/03 by the treating chiropractor and began a course of post injection rehabilitation.

Requested Services

Neuromuscular shock unit, durable med equip, ov, ther exer, unusual travel, hot/cold pack ther, elec stim unattend, myofas rel, ultrasound, mech tract from 5/21/03 through 9/12/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Operative report 5/9/03
2. Office notes 4/14/03 – 9/9/12/03
3. CT scan report 4/23/03
4. MRI scan report 4/15/03
5. X-Ray report 3/14/03

Documents Submitted by Respondent:

1. Daily note 6/19/03
2. Impairment rating 5/21/03
3. Peer review 6/17/03

Decision

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

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his back on ____. The ___ chiropractor reviewer also noted that the patient underwent an epidural steroid injection on 5/22/03, followed by post injection rehabilitation. The ___ chiropractor reviewer explained that post injection therapy is medically necessary for this patient's treatment. However, the ___ chiropractor reviewer also explained that there is no documentation provided that would indicate the need for unusual travel. The ___ chiropractor reviewer noted that on 5/21/03, there is documentation of billing for the purchase of an EMS unit with supplies. However, the ___ chiropractor reviewer explained that there is no medical documentation from 5/21/03 that indicated the medical rationale for the need to purchase the EMS. The ___ chiropractor reviewer also explained that without documentation to show the medical necessity for continued use of the EMS machine, the purchase and supplies are not medically necessary to treat this patient's condition. The ___ chiropractor reviewer noted that the patient was treated with various modalities between 7/28/03 through 9/12/03. The ___ chiropractor reviewer explained that there was subjective and objective documentation regarding this patient's flare ups and previous symptoms. The ___ chiropractor reviewer also explained that the treatment provided for the flare ups fell within the National Spine Society's Guidelines for low back pain specifically episodic and recurrence of symptoms. Therefore, the

___ chiropractor consultant concluded that the unusual travel from 5/21/03 through 9/12/03 and purchase of an EMS on 5/21/03 were not medically necessary to treat this patient's condition. However, the ___ chiropractor consultant concluded that the durable med equip, ov, ther exer, hot/cold pack ther, elec stim unattend, myofas rel, ultrasound, mech tract from 5/21/03 through 9/12/03 were medically necessary to treat this patient's condition.

Sincerely,