

MDR Tracking Number: M5-04-2624-01

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. The dispute was received on 4-19-04.

The following disputed dates of service were withdrawn by the requestor on July 30, 2004 and therefore will not be reviewed by the Division: 7/1/03 through 7/7/03.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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 the only issue** to be resolved. The following services and dates of service **were found** to be medically necessary:

- **CPT code 99213**: Level III office visits on 6/20/03, 6/23/03, 6/25/03, and 6/27/03.
- **CPT code 97530**: Therapeutic activities on 6/20/03 (1 unit), and 6/25/03
- **CPT code 97110**: Therapeutic exercises on 6/20/03, 6/23/03, 6/25/03 and 6/27/03.

The therapeutic activities rendered on 6/23/03 and 6/27/03; and the electrical stimulation, hot/cold packs therapy, mechanical traction, massage therapy, manual traction, and myofascial release services rendered from 6/12/03 through 6/17/03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 dates of service 6/20/03 through 6/27/03 as outlined above 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 10<sup>th</sup> day of August 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division  
RLC/rlc

07/24/2004

AMENDED REPORT

MDR Tracking #: M5-04-2624-01

IRO #: 5284

\_\_\_ 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.

This case was reviewed by a licensed Chiropractor. 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

\_\_\_ was injured on \_\_\_ due to an on the job injury. He was initially treated by an unknown therapist (according to the Designated Doctor) and chose to see \_\_\_ due to previously receiving treatment with him for an automobile accident. An MRI was performed on 3/21/03 of the cervical and lumbar spine. The results were of osteophytosis with posterior herniation at C4/5 yielding severe right paracentral spinal stenosis and impinging on the C5 nerve root, osteophytosis at C5/6 with moderate right paracentral spinal and foraminal stenosis, small bulge at C6/7 leading to right paracentral and foraminal stenosis bilaterally, L3/4 bulge with facet hypertrophy and L4/5 protrusion with annular tear yielding neural foraminal stenosis and facet hypertrophy. He was referred to \_\_\_ for medicinal management and injection consultations. He received two ESI's in the cervical and the lumbar spine per the records.

DISPUTED SERVICES

The dispute services include: electrical stimulation, hot/cold packs, mechanical traction, massage therapy, manual traction, office visit, myofascial release, therapeutic activities and therapeutic exercises as denied by the carrier with "U" codes.

DECISION

The reviewer disagrees with the previous adverse determination for the following services: 99213 on DOS 6/20/03, 6/23/03, 6/25/03, 6/27/03. 97530 on DOS 6/20/03 (1 unit), 6/25/03, 97110 Three Units on the following DOS 6/20/03, 6/23/03, 6/25/03, 6/27/03.

The reviewer agrees with the previous adverse determination for all remaining services.

BASIS FOR THE DECISION

The reviewer indicates that this patient had a great deal of problems that would have been complicating factors to the recovery of this patient. Active rehabilitation is a prudent and necessary activity to recover from multiple disc herniations with foraminal stenosis. Passive therapies should not have been provided at this late stage of treatment as they help to foster chronicity.

The patient was undergoing both active therapy protocols and injection management. The reviewer indicates his sources for information are the American College of Occupational and Environmental Medicine Guidelines and the NASS phase III 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 \_\_\_, Inc, \_\_\_, 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.

Sincerely,