

MDR Tracking Number: M5-04-2962-01

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.

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the dates of service in dispute. The Commission received the medical dispute resolution request on 5-10-04, therefore the following dates of service are not timely: 5/2/03-5/9/03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the 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** 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 the only issue** to be resolved. The electrical stimulation, myofascial release, joint mobilizations, ultrasound therapies, chiropractic manual treatments, therapeutic exercises, functional capacity evaluation, office visit (CPT code 99214), and hot/cold packs therapy rendered from 5/12/03 through 8/18/03 **were found** to be medically necessary. The office visits (CPT code 99213) from 5/12/03 through 8/18/03 **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 outlined above as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- in accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Decision and Order is hereby issued this 26th day of January 2005.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

August 13, 2004

AMENDED LETTER 10/12/2004

Rosalinda Lopez
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 #: M5-04-2962-01
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 care. 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 29 year-old male injured his low back on ____, resulting in chronic low back pain and weakness. He continues treatment with active rehabilitation as well as passive modalities for his diagnoses of left lumbar-5 radiculopathy with motor weakness and herniated nucleus pulposus at lumbar 4-5.

Requested Service(s)

Office visits, electrical stimulation, ultrasound, hot/cold pack therapy, myofascial release, joint mobilization, therapeutic exercises, functional capacity examination (FCE) and chiropractic manual treatment from 05/12/03 through 08/18/03.

Decision

It is determined that the electrical stimulations (attended), the myofascial release, the joint mobilizations, the ultrasound therapies, the chiropractic manual treatments, the therapeutic exercises, the office visits (99214), FCE and the hot/cold pack therapies from 05/12/03 through 08/18/03 are approved as medically necessary in the treatment of this patient's condition. However, the office visits (99213) from 05/12/03 through 08/18/03 are denied as not medically necessary to treat the patient's medical condition.

Rationale/Basis for Decision

The medical record submitted adequately documents that the patient sustained a significant injury to his lumbar spine warranting treatment. According to the medical record, the patient initially received rest and medication only, and did not begin active treatment until 04/29/03, nearly one month post injury. The dates of this dispute began on 05/12/03, less than 2 weeks into his active care. Due to the severity of the injury documented on a lumbar magnetic resonance imaging (MRI) scan, as well as the objective clinical findings and the deficiencies still present on the 07/08/03 functional capacity

evaluation, the medical necessity of physical therapy and rehabilitation throughout the time frame in dispute was sufficiently supported.

However, as far as the office visits (99213) were concerned, the daily treatment notes for the dates in dispute indicated that spinal manipulation was not performed on those encounters. Therefore, neither the diagnosis nor the records submitted supported the medical necessity of performing an expanded problem-focused evaluation and management service on each and every patient encounter, particularly during an already-established treatment plan.

Therefore, the electrical stimulation, myofascial release, joint mobilization, ultrasound therapy, chiropractic manual treatment, therapeutic exercise, office visits (99214), FCE and hot/cold pack therapy from 05/12/03 through 08/18/03 are approved as medically necessary in the treatment of this patient's condition. However, the office visits (99213) from 05/12/03 through 08/18/03 are denied as not medically necessary to treat the patient's medical condition.

Sincerely,

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

GBS:vn