

MDR Tracking Number: M5-04-3340-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 6-2-04.

The IRO reviewed office visits, hot/cold packs, manual electrical stimulation, therapeutic activities, myofascial release, mechanical traction, and ultrasound on 6-2-03 to 8-11-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO concluded that the office visits on 6-2-03, 6-11-03, 6-30-03, and 7-30-03 were medically necessary. The IRO agreed with the previous determination that the office visits, hot/cold packs, manual electrical stimulation, therapeutic activities, myofascial release, mechanical traction, and ultrasound from 6-02-03 to 8-11-03 were not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 7-20-04, 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.

On 10-14-04, the requestor submitted a letter of withdrawal for the fee issues.

ORDER

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, 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 6-2-03 through 7-30-03 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 Order is hereby issued this 28th day of October 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Amended Decision

10/26/2004

David Martinez
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-04-3340-01
IRO #: 5284

Specialty IRO 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 Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty 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 Specialty IRO 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 Specialty IRO 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 ___ while working for ___. He underwent treatment with Accident and Injury Chiropractic and multiple referral doctors. An MRI dated 9/24/01 indicated at L3/4 2mm traction annular disc bulge and spur material effacing the thecal sac mildly narrowing the lateral recess and both foramen, L4/5 2mm protrusion effacing the thecal sac mildly narrowing the lateral recess and both foramen and a 20% compression fracture of L1. He apparently suffered a new injury or an exacerbation of the old injury on ___ depending on which party's paperwork one reads. ___ filed a TWCC 41 on 7/10/03 indicating a new injury; however, the treating doctor, Dr. R, notes throughout his records that this is an exacerbation/aggravation of the old injury. A designated doctor Dr. P opined of an impairment rating of 5% with a date of MMI on 1/21/02. The date of this exam was 10/21/03. Dr. M indicated a 5% impairment with a date of MMI of 3/18/04 after ___ finished a pain management program. It is apparent that Dr. R attempted to get multiple tests authorized with little luck during the course of his treatment.

DISPUTED SERVICES

Disputed services include office visits, hot/cold packs, manual electrical stimulation, therapeutic activities, myofascial release, mechanical traction and ultrasound from 6/2/03 through 8/11/03.

DECISION

The reviewer disagrees with the previous adverse determination for the office visit (99204) on date of service (6/2/03) and office visit (99214) on DOS (6/30/03 and 7/30/03) and office visit (99213) on 6/11/03.

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

BASIS FOR THE DECISION

The reviewer indicates that the presence of a new injury or the presence of an exacerbation appears to be a mute point. Diagnostic testing would appear to help to determine if the injury was an exacerbation or a new injury. Regarding the services in question, it is not appropriate to perform passive therapies three to five months beyond an exacerbation. It is well documented that the patient has a muscle stimulation unit which apparently helps him greatly. Next, a level four office visit is not necessary or appropriate on each visit. These office visits should be performed on a monthly basis according to the Mercy Guidelines.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,