

MDR Tracking Number: M5-04-3643-01

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 (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 June 28, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic exercises, office visits, manual therapeutic techniques, electrical stimulation, hot/cold pack therapy, and neuromuscular re-education rendered on 8/1/03 through 11/4/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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 August 20, 2004, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Rationale
8/1/03	99080-73	\$15.00	\$0.00	V	\$15.00	The carrier denied CPT Code 99080-73 with a V for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. The requestor did not submit relevant information to support delivery of service. Reimbursement is not recommended.
11/4/03	99080-73	\$15.00	\$0.00	V	\$15.00	
TOTAL		\$30.00	\$0.00		\$30.00	

This Decision is hereby issued this 22<sup>nd</sup> day of October 2004.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division  
MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION

October 11, 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 #: M5-04-3643-01  
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 37 year-old female developed lower back pain while pushing an air conditioning unit on \_\_\_\_\_. She has been treated with medication, extensive physical therapy, and chiropractic therapies since the date of injury.

### Requested Service(s)

Therapeutic exercises, office visits, manual therapeutic techniques, electrical stimulation, hot/cold pack therapy, and neuromuscular reeducation for dates of service 08/01/03 through 11/04/03.

### Decision

It is determined that therapeutic exercises, office visits, manual therapeutic techniques, electrical stimulation, hot/cold pack therapy, and neuromuscular reeducation were not medically necessary to treat this patient's medical condition from 08/01/03 through 11/04/03.

### Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type, and duration of services must be reasonable and consistent with the standards of the health care community. Those criteria were not met in this case.

While the provider's letter of 01/20/04 requested reimbursement for the disputed treatment under the provisions of the Texas Labor Code 408.021, the records fail to substantiate that the services fulfilled the statutory requirements. Specifically, the patient obtained no relief, with her pain rating at 7 on a scale of 10 at the beginning and end of treatment; promotion of recovery was not accomplished since surgery had been recommended and requested; and there was no enhancement of the employee's ability to return to employment. Therefore, it is determined that therapeutic exercises, office visits, manual therapeutic techniques, electrical stimulation, hot/cold pack therapy, and neuromuscular reeducation were not medically necessary to treat this patient's medical condition from 08/01/03 through 11/04/03.

Sincerely,