

MDR Tracking Number: M5-04-3719-01

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 24, 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 office visits, physical therapy evaluation, electrical stimulation manual therapy technique, neuromuscular re-education, group therapy, and therapeutic exercises 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 the only issue** to be resolved. As the office visits, physical therapy evaluation, electrical stimulation manual therapy technique, neuromuscular re-education, group therapy, therapeutic exercises treatment rendered from 11/20/03 through 1/16/04 were not found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On September 19, 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	MAR	EOB Denial Code	Rationale
12/1/03	99213	\$29.74	\$0.00	\$52.17 x by 125% equals \$65.22 (MAR)	None	Review of the Table of disputed services reflects the requestor desires reimbursement in the amount of \$29.74 for CPT code 99213 rendered on 12/1/03. Review of the EOBs submitted by the carrier reflects this CPT code as paid, however the requestor does not indicate on the Table payment. Therefore the disputed charge will be reviewed according to the Medicare Fee Schedule. According to the TWCC Rule 134.202(d)(1) "In all cases, reimbursement shall be the least of the: MAR amount as established by this rule". Therefore, the requestor is entitled to reimbursement in the amount of \$29.74.
TOTAL		\$29.74	\$0.00	\$65.22		

**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 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 date of service rendered on 12/1/03 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 8<sup>th</sup> day of October 2004.

Margaret Q. Ojeda  
 Medical Dispute Resolution Officer  
 Medical Review Division

MQO/mqo

## NOTICE OF INDEPENDENT REVIEW DECISION

September 10, 2004

**AMENDED LETTER 09/27/04**

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 #: M5-04-3719-01  
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 Medicine. 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 is a 42 year-old male patient who was involved in a work related event on \_\_\_\_\_. The claimant was stacking a 45 pound container onto a 6-foot high pallet when the pallet fell backwards. He attempted to catch the object and felt an immediate onset of left shoulder and mid-back pain. He was initially treated with medications and a 6-week trial of physical therapy applications. A magnetic resonance imaging (MRI) study of the thoracic spine done 06/18/03 revealed the presence of a 2 to 3 millimeter thoracic disc protrusion/herniation pressing against the thecal sac to the right. The patient changed his attending doctor to a doctor of chiropractic medicine in November of 2003. Evaluation of the patient on 11/05/03 revealed that he had a thoracic strain/sprain. The doctor implemented 19 sessions of therapeutics from 11/20/03 through 01/06/04.

### Requested Service(s)

Office visits (excluding 12/01/03), physical therapy evaluation, electrical stimulation, manual therapy techniques, neuromuscular reeducation, therapeutic exercises and group therapy for dates of service 11/20/03 through 01/16/04.

### Decision

It is determined that office visits (excluding 12/01/03), physical therapy evaluation, electrical stimulation, manual therapy techniques, neuromuscular reeducation, therapeutic exercises and group therapy were not medically necessary for the treatment of this patient's medical condition from 11/20/03 through 01/16/04.

### Rationale/Basis for Decision

The provider diagnosed this patient with a strain/sprain injury over the thoracic spine and implemented 19 sessions of physical therapy management from 11/20/03 through 01/16/04. The disc protrusion was not shown to be a definitive pain generator in this patient's pain complex and there is no medical evidence to support the use of intensive physical therapy applications with a patient who is placed in a strain/sprain algorithm. Management of this claimant's medical conditions from 11/20/03 through 01/16/04 is not medically necessary and/or reasonable based upon the documents submitted for this review.

Sincerely,