

MDR Tracking Number: M5-04-4025-01

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 July 22, 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, electrical stimulation unattended, therapeutic exercises, electrodes, therapeutic activities, hot/cold packs, ultrasound, manual therapy technique, and an evaluation rendered on 7/24/03 through 10/30/03 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 17, 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	Rationale
9/24/03	97750 x4 units	\$140.00	\$66.82	JF	Review of the carriers EOB dated 11/9/03 revealed the carrier denied CPT code 97750, as "JF-Documentation submitted does not substantiate the service billed." Review of the carriers' reconsideration EOB dated 7/8/04 revealed the carrier denied CPT code 97750, as "NK-Documentation does not support the need for more than 30 minutes of time." Review of the requestor's physical performance evaluation report dated 9/24/03, meets the documentation criteria set forth by the medical fee guideline. The requestor is entitled to an additional reimbursement in the amount of \$66.82.
TOTAL		\$140.00	\$66.82		The requestor is entitled to reimbursement in the amount of \$66.82.

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 9/24/03 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 8th day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION

Date: September 28, 2004

RE:

MDR Tracking #: M5-04-4025-01

IRO Certificate #: 5242

_____ 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 _____ 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 proposed 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 an Orthopedic reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The reviewer 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Letter of Medical Necessity by _____ of _____
- Clinical documents from _____

Submitted by Respondent:

- None

Clinical History

The claimant has a history of chronic back pain allegedly related to a work injury that occurred on _____. The claimant was treated conservatively. Conservative treatment including physical therapy sessions. An MRI reportedly showed no disc herniation and no significant neurocompressive lesions of the lumbar spine.

Requested Service(s)

Office visits, (97014/G0283) electrical stimulation unattended, (97110) therapeutic exercises, (A4556) electrodes, (97530) therapeutic activities, (97010) hot/cold packs, (97035) ultrasound, (97140) manual therapy technique, and (97001) evaluation for dates of service 7/24/03 through 10/30/03.

Decision

I agree with the insurance carrier that the requested services are not medically necessary.

Rationale/Basis for Decision

Generally, physical therapy is indicated in the presence of significant deficits in functional capacity and range of motion usually associated with acute injury and/or peri-operative conditions. The claimant allegedly sustained a low energy lifting injury consistent with self-limited sprain/strain of the lumbar spine on _____. By 7/24/03, at the time of initial evaluation by _____, the claimant demonstrated full active range of motion of the lower extremities, good dynamic and static standing balance, and exhibited normal sitting and standing postures. There is no clearly documented clinical rationale explaining why a well structured home exercise program and ice/heat modalities would be any less effective than continued active intervention in this clinical setting. There is no documentation of exhaustion of usual and customary measures of self help treatment including, but not limited to, oral non-steroidal and corticosteroid anti-inflammatory medication, bracing and instruction in dynamic spinal stabilization techniques.