

MDR Tracking Number: M5-04-4027-01

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, 133.307 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 08-29-03.

The IRO reviewed office/outpatient visits (excluding 11-21-02), therapeutic activities, therapeutic exercises, joint mobilization and supplies and materials rendered from 10-29-02 through 01-03-03 that were denied based "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of the issues of medical necessity. The office/outpatient visits, therapeutic activities, therapeutic exercises, joint mobilization and supplies and materials for dates of service 10-29-02 through 11-13-02 **were** found to be medically necessary. The office/outpatient visits (excluding 11-21-02), therapeutic activities, therapeutic exercises, joint mobilization and supplies and materials for dates of service from 11-14-02 through 01-03-03 **were not** found to be 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.

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 07-29-04, 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.

The requestor nor respondent submitted explanation of benefits for CPT code 99213 date of service 11-21-02. Reimbursement in the amount of \$48.00 per the 1996 Medical Fee Guideline is recommended. CPT code 99080-73 date of service 01-02-03 denied with denial code "F". The requestor submitted relevant information to support delivery of service. Reimbursement in the amount of \$15.00 is recommended per Rule 133.106(f). Total reimbursement of \$63.00 is recommended.

This Findings and Decision is hereby issued this 16th day of September 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 Decision is applicable for dates of service 10-29-03 through 01-02-03 in this dispute.

This Order is hereby issued this 16th day of September 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

September 10, 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 #: M5-04-4027-01
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 40 year-old female patient injured her low back on ____, resulting in a diagnosis of lumbar strain with left radiculopathy. She has received extensive treatment with physical therapy, chiropractic treatment, lumbar facet injections, and work conditioning with little improvement

Requested Service(s)

Office/outpatient visits, therapeutic activities, therapeutic exercises, joint mobilization, and supplies and materials for dates of service 10/29/02 through 01/03/03, excluding the office visit on 11/21/02.

Decision

Based upon the review of the provided records, it is determined that office/outpatient visits, therapeutic activities, therapeutic exercises, joint mobilization, and supplies and materials were medically necessary to treat this patient's medical condition from 10/29/02 through 11/13/02.

However, the office/outpatient visits (excluding 11/21/02), therapeutic activities, therapeutic exercises, joint mobilization, and supplies and materials provided from 11/14/02 through 01/03/03 were not medically necessary to treat this patient's medical condition.

Rationale/Basis for Decision

The records indicate that the patient received physical therapy 3 times per week for eight weeks following her injury of _____. She then changed treating doctors and was evaluated by her new doctor on 09/18/02. A functional capacity examination was performed on 09/23/02 and an aggressive treatment program was begun. Treatment was rendered for 11 visits from 10/02/02 through 10/25/02.

She was referred to a specialist in pain control for evaluation and facet injections were recommended. On 11/14/02, following an appropriate 2 week trial of treatment, the report from the specialist's office indicated that the patient's lumbar pain remained at an 8 on a scale of 10. This continued high pain scale indicates that continuation of the same or similar treatment did not meet the national standard of care. Therefore, in-office supervised treatment and rehabilitation from 11/14/02 through 01/03/03 (excluding the office visit on 11/21/02) were not medically necessary to treat this patient's medical condition.

Sincerely,