

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 09-14-04.

The IRO reviewed office visits, electrical stimulation, ultrasound, manual therapy, therapeutic exercises for dates of service 12-01-03 through 02-04-04 and durable medical equipment for date of service 01-12-04 that were denied based upon "U".

The IRO determined that the office visits, manual therapy and therapeutic exercises for dates of service 12-01-03 through 02-04-04 **were** medically necessary. The IRO further determined that the electrical stimulation and ultrasound for dates of service 12-01-03 through 02-04-04 and the durable medical equipment for date of service 01-12-04 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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 12-29-04, 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.

Review of CPT code 97014 listed on the table of disputed services for date of service 12-22-03 revealed that neither party submitted an EOB. Per Rule 133.307(e)(2)(A) the requestor did not provide a HCFA as proof of submission to the carrier. No reimbursement recommended.

CPT code 97010 date of service 01-26-04 denied with a "G" denial code (global). Per the Medicare Local Coverage Determination (LCD) this is a bundled service code and considered an integral part of a therapeutic procedure(s). No reimbursement recommended.

This Findings and Decision is hereby issued this 2nd day of February 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

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 Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), 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 12-01-03 through 02-04-04 in this dispute.

This Order is hereby issued this 2nd day of February 2005.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

November 18, 2004

Amended Letter 01/19/05

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 #: M5-05-0208-01
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 45 year-old female injured her neck, back and head on ___ when she slipped and fell in a restroom. Her diagnosis is lumbar radiculopathy and lumbar discogenic pain syndrome. She has been treated with therapy, medications and surgery.

Requested Service(s)

Office visits, electrical stimulation, ultrasound, manual therapy and therapeutic exercise for dates of service 12/01/03 through 02/04/04

Durable Medical Equipment (DME) for date of service 01/12/04

Decision

It is determined that there is medical necessity for the office visits, manual therapy and therapeutic exercise for the dates of service 12/01/03 through 02/04/04. However, it is determined that there is no medical necessity for electrical stimulation and ultrasound for dates of service 12/01/03 through 02/04/04 nor the Durable Medical Equipment (DME) for date of service 01/12/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Treatment guidelines allow for a trial of chiropractic care and the utilization of passive therapy (electrical stimulation and ultrasound) with a progression into active therapy (manual therapy and therapeutic procedures) for these types of injuries. There are no guidelines for the use of passive therapy after the first 6 weeks from the date of injury. Additionally, there is no medical documentation to indicate the specific anatomical, clinical, and/or rehabilitative justification for the use of DME. Therefore, the electrical stimulation and ultrasound from 12/01/03 through 02/04/04 and DME for date of service 01/12/04 were not medically necessary to treat this patient's medical condition. However, the office visits, manual therapy and therapeutic exercises were medically necessary for the treatment and on going evaluation of this patient's progress for the dates of service 12/01/03 through 02/04/04.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm
Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-0208-01

Information Submitted by Requestor:

- Position Statement
- Treatment Records
- Progress Notes
- Consult
- Diagnostic Tests

Information Submitted by Respondent:

- Galaxy Center Notes
- Procedures
- Physical Therapy Notes
- Diagnostic Tests
- Pain Clinic Notes
- Daily Notes – Dr. Denman
- Progress Notes – Dr. Baker
- Letters of Medical Necessity
- Consults
- Claims