MDR Tracking Number: M5-05-0531-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 4-1-03.

Dates of service prior to 4-1-02 were submitted untimely per Rule 133.308 and will not be considered in this decision.

The IRO reviewed the medical necessity of a hot tub that was denied based upon "V" purchased on 9-20-02.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. 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.

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

The requestor wrote on 5-18-04 that she "called and talked with Marsha Crockett and also faxed her the attachment requesting documentation of denials. She told me 'No." I told her I had never received denials from the other adjustors. I got verbal no's from the previous adjustors. Now, what do I do? I'm faxing Hot Tub Bill, 10 pages of massage disputed services as requested. The total for massages is $5710.00."

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services identified below. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
4-5-02 4-12-02 4-20-02 5-3-02 5-4-02 5-7-02 5-14-02 5-24-02 5-31-02 6-7-02 6-11-02 6-18-02 6-28-02 7-6-02 7-12-02 7-25-02 8-2-02 8-8-02	97124	$40.00 $40.00 $75.00 $30.00 $50.00 $50.00 $50.00 $50.00 $40.00 $25.00 $50.00 $50.00 $50.00 $50.00 $50.00 $50.00 $50.00 $50.00	$0.00	No EOB	$28.00	CPT Code Descriptor	2-14-01 Intracorp peer review reported that myofascial therapy was not medically necessary. 10-31-01, Intracorp denied preauthorization request for 24 massage therapy sessions. Requestor submitted payment receipts for massage therapy on 5-22-02, 6-6-02 which are not dates on TWCC-60. BRC held on 1-16-04 found that depression was causally related from compensable injury. Requestor submitted copies of checks for date of service, 4-5-02, 4-12-02, 4-20-02, 5-3-02, 5-4-02, 5-7-02, 5-24-02, 5-31-02, 6-7-02, 6-11-02, 6-18-02, 6-28-02, 7-6-02, 7-12-02, 7-25-02. The documentation did not contain a check or receipt for 5-14-02, 8-2-02 and 8-8-02. The requestor is entitled to reimbursement of $710.00.
TOTAL							The requestor is entitled to reimbursement of **$710.00.**

IV. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to reimbursement for CPT code(97124) in the amount of **$710.00** Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **$710.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 19th day of November 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

July 16, 2004

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 #: M5-04-2457-01
New MDR Tracking #: M5-05-0531-01
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 §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 TMF physician reviewer who is board certified in family practice which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in1976. The TMF physician 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 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 46-year-old female had a work related injury on ___. She lifted a 53-pound fire extinguisher out of a truck and complained of neck pain. The patient was treated with physical therapy, oral pain medications, injections, imaging studies, massage therapy, and psychiatric treatment.

Requested Service(s)/Equipment

Hot tub for 09/20/02

Decision

It is determined that the hot tub for 09/20/02 was not medically necessary.

Rationale/Basis for Decision

This 46-year-old female with work injury on ___, sustained a strain of the neck. She underwent multiple treatments to include: medications, massage therapy, and chiropractic treatment. Her MRI was negative. There is documentation of a larger psychiatric overlay present; the pain is not related to injury. Therefore, the hot tub for 09/20/02 is not medically necessary to treat this patient's condition.

Sincerely,

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

GBS:vn