

MDR Tracking Number: M5-05-0684-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 10-28-04.

The IRO reviewed DME, self care management training, office visit, manual therapy technique, ultrasound, massage, therapeutic exercises, and mechanical traction.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the 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 \$650.00** 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 11-30-04, 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.

Code 97140 billed for date of service 4-20-04 and 4-21-04 were paid per the EOB dated 8-20-04. Therefore, no dispute exists.

Code 99212 billed for date of service 4-26-04, 4-28-04, and 4-30-04 was denied as "N – documentation does not support the service billed." Documentation submitted supports level of service billed. Recommend reimbursement of  $\$35.33 \times 125\% = \$44.16 \times 3 = \$132.48$ .

The above Findings and Decision is hereby issued this 31st day of December 2004.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

### **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 outlined above as follows:**

- In accordance with Medicare program reimbursement methodologies for dates of service on or after 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 Order is applicable to dates of service 4-19-04 through 6-11-04 as outlined above 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 31st day of December 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

Enclosure: IRO Decision

December 30, 2004

Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

Re: Medical Dispute Resolution  
MDR #: M5-05-0684-01  
TWCC#:  
Injured Employee:  
DOI:  
SS#:  
IRO Certificate No.: IRO 5055

Dear Ms. \_\_\_\_:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating

physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Neurology and Pain Management and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme  
Secretary & General Counsel

GP:thh

### **REVIEWER'S REPORT M5-05-0684-01**

#### **Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

- Letter of medical necessity
- Office notes 04/19/04 – 06/14/04
- Physical therapy notes 04/20/04 – 06/11/04
- Nerve conduction study 06/02/04
- Radiology report 05/19/04

#### **Clinical History:**

This claimant sustained a work-related injury on \_\_\_\_, and noticed a sudden “pop” in the lower back. He was evaluated the following day, and was given the diagnosis of lumbosacral sprain/strain, and suggested some treatment for acute strain including certain physical therapy modalities, Cryopak, Biofreeze, and referral to an orthopedic surgeon for further evaluation and treatment. The claimant was also referred for EMG/NCV studies, as well as MRI of the lumbosacral spine, while undergoing the physical therapy modalities for treatment. The claimant was also evaluated at a spine center. The surgeon's notes indicate that the EMG studies were positive for L5/S1 nerve root irritation, and prescribed some medications, including Ultracet, Soma, and noted that the claimant had made improvements in his physical therapy treatments. Conservative treatment was recommended to be ongoing at that time.

#### **Disputed Services:**

Cryopak & Biofreeze, self-care management training, office visit, manual therapy technique, ultrasound, massage therapy, therapeutic exercises and mechanical traction during the period of 04/19/04 – 06/11/04,

**Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were medically necessary in this case.

**Rationale:**

It appears that many of the services that are being denied were offered in the acute setting, the day after the patient sustained his injury and presented the following day to for evaluation. In the opinion of the reviewer, the recommendations for treatment were appropriate for initial attempts at an acute lumbar strain or sprain. Therefore these services and treatment modalities were appropriate and medically necessary.