

MDR Tracking Number: M5-05-1982-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 3-15-05.

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

The IRO reviewed office visits, electrical stimulation, therapeutic exercises, massage therapy, manual therapy technique, tens two lead, unlisted therapeutic procedure, and mechanical traction from 5-5-05 through 5-21-04 denied by the carrier for medical necessity.

The office visits, electrical stimulation, 4 units of therapeutic exercises on each date of service, 2 units of manual therapy technique, tens two lead, and mechanical traction from 5-5-05 through 5-21-04 **were found** to be medically necessary. The massage therapy, unlisted therapeutic procedure, more than 4 units of therapeutic exercises and more than 2 units of manual therapy **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. The amount due the requestor for the medical necessity issues is \$2,468.42.

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 totaling \$2,468.42 from 5-5-04 through 5-21-04 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 Findings and Decision and Order is hereby issued this 9th day of June, 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

May 20, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-1982-01
TWCC #:
Injured Employee:
Requestor: Valley Spine Medical Center
Respondent: American Home Assurance/ARCM
MAXIMUS Case #: TW05-0076

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related on _____. The patient reported that while at work he injured his back unloading a truck when he lifted a heavy computer. Initial diagnoses for this patient included lumbar sprain/strain and muscle spasms. The patient underwent an MRI of the lumbar spine on 4/13/04, and an EMG/NCV on 6/10/04. The current treating diagnoses for this patient include lumbar sprain/strain, discogenic muscle spasms, and lumbar disc displacement (disc bulge). Treatment for this patient's condition has included physical therapy, TENS unit, LSO, lumbar facet block and medications consisting of Ultracet, Carisoprodol, and Hydrocodone.

Requested Services

99212-ov, electrical stimulation, therapeutic exercises, massage therapy, manual therapy technique, tens two lead, unlisted therapeutic procedure, and mechanical traction from 5/5/04 through 5/21/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Request for Reconsideration 6/17/04, 10/25/04
2. Progress Notes 5/5/04 – 5/21/04
3. Therapeutic Chart 3/30/04 – 5/18/04
4. EMG/NCV report 6/10/04
5. MRI report 4/13/04
6. Operative Note 8/18/04
7. FCE report 5/25/04

Documents Submitted by Respondent:

1. Independent Review Organization Summary 4/14/05
2. MRI report 4/13/04
3. EMG/NCV report 6/10/04
4. Physical Therapy Notes 3/30/04 – 5/21/04
5. FCE reports 5/25/05 and 10/1/04

Decision

The Carrier's denial of authorization for the requested services is partially overturned.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his back on _____. The MAXIMUS chiropractor reviewer indicated that this patient had a disc compression and facet joint inflammation syndrome that is made worse by lifting (part of his work duties). The MAXIMUS chiropractor reviewer noted that the patient was getting symptomatic relief and was able to keep working most of the first 2 months after the injury. However, the MAXIMUS chiropractor reviewer also noted that the treatment didn't correct his problem until he underwent facet joint injections. The MAXIMUS chiropractor reviewer explained that 6-8 weeks of active and passive therapy is acceptable treatment following a work related injury. The MAXIMUS chiropractor reviewer indicated that treatment after this time frame needs to be documented as objectively and subjectively improving this patient's condition. The MAXIMUS chiropractor reviewer explained that there was enough progress to warrant care that is outlined until 5/21/04 (about 8 weeks after the injury and 25 visits overall). The MAXIMUS chiropractor reviewer indicated that treatment after 5/21/04 was not documented to be objectively and subjectively improving this patient's condition and therefore was not medically necessary.

The MAXIMUS chiropractor reviewer explained that there is no documented benefit to the massage given to this patient or how it was administered. The MAXIMUS chiropractor reviewer indicated that the documentation provided did not support the medical necessity of therapeutic exercises performed to fill 2 hours of one on one time. The MAXIMUS chiropractor reviewer explained that 1 hour (4 units) of therapy is medically necessary treatment for the documented program. The MAXIMUS chiropractor reviewer also explained that the documentation provided did not support the need for unlisted therapeutic massage. Therefore, the MAXIMUS chiropractor consultant concluded that the office visits (99212), electrical stimulation (G0283), mechanical traction (97012), and TENS two lead (E-720) from 5/5/04 through 5/21/04 were medically necessary to treat this patient's condition. The MAXIMUS chiropractor consultant also concluded that 4 units of therapeutic exercises (97110) and 2 units of manual therapy (97140) from 5/5/04 through 5/21/04 were medically necessary to treat this patient's condition. However, the MAXIMUS chiropractor consultant further concluded that the massage therapy (97124) and therapeutic exercises (97110) from 5/5/04 through 5/21/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department