MDR Tracking Number: M5-03-0005-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 IRO reviewed the physical therapy services rendered from 10-23-01 to 2-11-01 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO concluded that physical performance test rendered on 11-20-01 was medically necessary. All other services in dispute were found to be not medically necessary. Therefore, the requestor is entitled to reimbursement of $200.00.

Consequently, the commission has determined that **the requestor did prevail** on the majority of the medical fees ($200.00). Therefore, upon receipt of this Order and in accordance with §133.308(q)(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.

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 May 22, 2003, 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 following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12/6/01	64999	$248.00	$29.35	F	DOP	Section 413.011(b)	Requestor did not submit documentation to support position that amount billed was fair and reasonable and complies with statute. Therefore, additional reimbursement is not due.
TOTAL		$4619.20					The requestor is not entitled to reimbursement.

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 11-20-01 through 12-6-01 in this dispute.

This Order is hereby issued this 5th day of August 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 10, 2003

Re: IRO Case # M5-03-0005

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient was injured on ___ when he was lifting a steel power line and felt a sharp pain in his low back. He was treated with conservative therapy and medications for several months. He also was given injections. On 7/25/01 a laminectomy and fusion procedure was performed at L5-S1. The patient had approximately nine weeks of physical therapy post surgically, but the pain continued in his low back radiating into his buttock with subjective weakness of the lower extremities bilaterally. The patient was given a 15% impairment rating. At the end of 2001 the patient came under the care of multiple pain management physicians. There is documentation in 2002 of a spinal cord stimulation trial and subsequent spinal cord implantation.

Requested Service
Medical services 11/20/01, 12/6/01

Decision
I agree in part and disagree in part with the carrier's decision to deny the requested treatment.

Rationale

I disagree with the denial of the Physical performance test 11/20/01. The rationale for its denial was that the completion of an FCE 10/19/01 made the testing on 11/20/01 unnecessary. Very little information, however, was provided on the 10/19 FCE. The FCE provided only some lumbar range of motion and cardiovascular endurance measurements. There are blank sheets indicating that the patient was unable to finish the test or the testers were unable to record any results. There were no descriptions of the patient's work duties or any limitations of functional deficits. The testing on 11/20/01 is a full 19-page FCE with both range of motion and strength testing.

I agree with the denial 11/20/01 of code 99213. No documentation was provided for this review supporting a level-3 office visit.

I agree with the denial of services on 12/6/01. A very brief procedure note describes an electro analgesic paravertebral regional nerve block to the lumbar region. A lumbar paravertebral regional nerve block appears to have been necessary on that day. The patient reported a flare up of low back pain described as "dreadful severe pain." The proper coding for what was necessary would be 64441. If some type of electrical device was used necessitating a different code, there was inadequate documentation to support its use. Furthermore, there is nothing in the literature supporting the efficacy of this technique.

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This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,