MDR Tracking Number: M5-03-0149-01

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 physical therapy sessions rendered from 1-23-02 to 3-18-02 that were denied based upon "U".

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(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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On Februray12, 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:

Services that were denied without an EOB will be reviewed in accordance with *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
1-17-02 4-22-02	99214	$85.00 $91.00	$0.00	F	$71.00	CPT Code Description	Documentation supports billed service, reimbursement of 2 X $71.00 = $142.00 is recommended.
1-29-02 2-5-02 2-7-02 2-8-02 2-13-02	97110	$40.00	$0.00	No EOB	$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	Documentation does not support 1 to 1 supervision. No reimbursement is recommended.
1-29-02 2-5-02 2-7-02 2-8-02	97010	$20.00	$0.00	No EOB	$11.00	CPT Code Description	Documentation supports billed service, reimbursement of 7 X $11.00 = $77.00 is recommended.

2-12-02 2-13-02 3-15-02							
1-29-02 2-5-02 2-7-02 2-8-02 2-12-02 2-13-02 3-15-02	97014	$25.00	$0.00	No EOB	$15.00	CPT Code Description	Documentation supports billed service, reimbursement of 7 X $15.00 = $105.00 is recommended.
1-29-02 2-5-02 2-7-02 2-8-02 2-12-02 2-13-02 3-15-02	97035	$25.00	$0.00	No EOB	$22.00 / 15 min	CPT Code Description	Documentation supports billed service, reimbursement of 7 X $22.00 = $154.00 is recommended.
2-12-02	97124	$35.00	$0.00	NO EOB	$28.00 / 15 min	CPT Code Description	Documentation supports billed service, reimbursement of $28.00 is recommended.
3-15-01	97110	$80.00	$0.00	D	$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	Documentation does not support 1 to 1 supervision. No reimbursement is recommended.
3-18-02	99213	$80.00	$48.00	F	$48.00		EOB indicates service paid.
TOTAL							The requestor is entitled to reimbursement of **$506.00.**

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

Elizabeth Pickle
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 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 8-28-01 through 12-28-01 in this dispute.

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.

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

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: December 13, 2002

Requester/ Respondent Address : Rosalinda Lopez
TWCC
4000 South IH-35, MS-48
Austin, Texas 78704-7491

RE: MDR Tracking #: M5-03-0149-01
IRO Certificate #: 5242

___ 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 ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed 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 an Internal Medicine physician reviewer who is board certified in Internal Medicine. The Internal Medicine 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 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

The records submitted for review are explanation of benefits forms from ___; office records of treating physician who referred the patient for physical therapy after seeing her in his office on 1/17/02; multiple physical therapy progress notes for the period noted including 20 sessions of physical therapy; consultant note from the doctor from 1/30/02; consultant note from a Pain Management specialist, who eventually performed a series of lumbar epidural and transforaminal epidural blocks; x-ray reports from 6/7/99 and 8/6/01 showing degenerative changes of the lumbar spine; MRI of the lumbosacral spine from 8/6/01 showing mild diffuse disc bulges at L1-L2, L3-L4, L5-S1 and moderate spinal canal stenosis at L3-L4 and L4-L5; and a sensory nerve conduction test from 8/9/01.

Briefly, the claimant was a 59 year-old woman with back pain. On ___, she was working in a daycare when she was pulled by a child and felt pain in her back and was unable to work as of the date of the

therapy administered beginning 1/18/02. Her pain was located in the lower back, was rated of moderate to severe intensity and was intermittently radiating into the left leg. When she saw the doctor on 1/30/02, the pain was rated 10/10. There were no warning signs or "red flags."

She was referred by the doctor on 1/17/02 for physical therapy which commenced on or about 1/23/02 and consisted of 20 sessions during the dates in question. The therapist's notes generally reflect ongoing pain in the range of 4-7/10 and that the patient was getting some relief of her symptoms with therapy and home exercises. Generally, the therapy consisted of McKenzie and other therapeutic exercises, hot or cold packs, ultrasound and electrical stimulation therapy.

The patient continued to have pain and went on to have epidural steroid injections in March. It appears to me that the insurer has denied all of the therapy based on the following explanation:

> "The treatment/service provided exceeds medically accepted utilization review criteria and/or reimbursement guidelines established for severity of injury, intensity of service and appropriateness of care."

No specific clinical guidelines were cited.

Requested Service(s)

Physical Therapy from 1/23/02 to 3/18/02

Decision

I disagree with the insurance carrier's denial and recommend that the services be covered.

Rationale/Basis for Decision

Although this patient did undergo a prolonged course of physical therapy, it appears that all service were denied. Based on the information provided for my review, My rationale is that this is a patient with what appears to be an exacerbation of chronic back pain, already on medical therapy and that physical therapy was a reasonable and conservative measure to see if her pain exacerbation could be controlled with physical therapy and a renewed home exercise program prior to any further invasive interventions. The therapy was also supported by both of her treating physicians.

While opinions vary on some of the specific modalities that are used in physical therapy, physical therapy is included as a recommended treatment modality for acute persistent back pain in many treatment guidelines that I have reviewed (**Herniated disc. In: North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialists:** LaGrange (IL): North American Spine Society (NASS); 2000. 104 p. [205 references]; **Adult low back pain:** Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2001 May. 50 p. [62 references]).

This decision by the IRO is deemed to be a TWCC decision and order.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requester and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 13th day of December 2002.