MDR Tracking Number: M5-03-0429-01

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 office visits, physical therapy, supplies and therapeutic procedures rendered from 1-14-02 to 5-8-02 that were denied based upon "U.

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.

On May 14, 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 denied without an EOB will be reviewed in accordance with Commission's *Medical Fee Guideline.*

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
4-25-02	97139PH	$35.00	$0.00	No EOB	DOP	Medicine GR (I)(C)(1)(r)	Documentation supports billed service $35.00.
4-25-02	99070PH	$7.00	$0.00	No EOB	DOP	General Instructions GR (IV)	Documentation supports billed service $7.00.
4-25-02	99212	$32.00	$0.00	No EOB	$32.00	CPT Code Description	Documentation supports billed service $32.00
TOTAL		$74.00					The requestor is entitled to reimbursement of **$74.00.**

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 $915.00 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 10-10-01 through 6-14-02 in this dispute.

This Order is hereby issued this 21st day of July 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 9, 2003

Re: IRO Case # M5-03-0429

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 Doctor of Chiropractic who is licensed by the State of Texas. 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 injured his lower back on ___ when he struggled to restrain a 16-year-old. He was taken to a doctor and given medicine and x-rayed. He was treated with physical therapy through 10/9/01. He then changed his treating doctor.

Requested Service
Physical therapy, office visit, phonophoresis and phono. supplies, spray and stretch 1/14/02-5/8/02

Decision
I agree with the carrier's decision to deny the requested treatment.

Rationale
Conservative treatment prior to the dates in dispute failed to give the patient any documented relief of his symptoms or improvement of function. The patient's conditioned had plateaued in a diminished condition by the time of the disputed treatment, and by then any further treatment would be ineffective in relieving symptoms or improving function. The documentation presented proves that the treatment was futile when, on the initial visit to the second treating doctor on 11/19/01 the patient's pain was 6/10, and on 4/18/02 his pain was documented as 7/10. A report of 4/18/02 notes numerous positive orthopedic tests, positive symptom magnification, palpable muscle hypertonicity and tenderness, exacerbation of pain with coughing and sneezing and loss of sensation in the L3-S1 dermatomes. These are all clinical objective findings that prove treatment has failed.
The documentation on the SOAP notes shows that only aquatic therapy and therapeutic exercises were used initially for the dates 1/14/02-2/11/02. This choice of therapy is questionable on a patient with documented positive orthopedic tests, paresthesia and a pain scale of 6/10. This treatment was inappropriate, over utilized and possibly iatrogenic.
The documentation was extensive, excessively repetitious, computer generated, and provided little, if any, beneficial clinical information to show that treatment was effective in relieving symptoms or improving function.
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This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,