

MDR Tracking Number: M5-03-0852-01

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 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 9-26-02.

The IRO reviewed physical therapy sessions, office visits, FCEs and injection rendered from 1-28-02 to 5-24-02 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 16, 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
2-6-02	97032	\$22.00	\$0.00	No EOB	\$22.00	CPT Code Description	SOAP note supports billed service, reimbursement of \$22.00 is recommended.
2-6-02	97035 (2 units)	\$44.00	\$0.00	No EOB	\$22.00 / 15 min	CPT Code Description	SOAP note supports billed service, reimbursement of \$44.00 is recommended.
2-6-02	97530 (2 units)	\$70.00	\$0.00	No EOB	\$35.00 / 15 min	CPT Code Description	SOAP note supports billed service, reimbursement of \$70.00 is recommended.

2-11-02	97750 (8 units)	\$344.00	\$0.00	No EOB	\$43.00 /body area	Medicine GR (1)(E)(3)	A report for testing on 2-11-02 was not submitted to support billed service. No reimbursement is recommended.
TOTAL		\$480.00					The requestor is entitled to reimbursement of <b>\$136.00.</b>

**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 1-28-02 through 6-24-02 in this dispute.

This Decision and Order is hereby issued this 3<sup>rd</sup> day of September 2003.

Elizabeth Pickle  
Medical Dispute Resolution Officer  
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

May 8, 2003

MDR Tracking #: M5-03-0852-01  
IRO Certificate #: IRO 4326

The \_\_\_ 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 §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the rendered 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 a \_\_\_ physician reviewer who is board certified in chiropractic care which is the same specialty as the treating physician. The \_\_\_ 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

This patient had an on the job injury \_\_\_ when she turned in her chair and lifted a box of files. She reported feeling a pull in her lower back and the left side, with pain radiating down the left leg. Her

x-rays have been normal. An MRI on 02/14/02 revealed moderate desiccation and central disc bulge/protrusion at L4-L5. She has attended many sessions of physical therapy involving various treatment modalities and trigger point injections in three areas.

Requested Service(s)

Physical therapy sessions, office visits, Functional Capacity Evaluations (FCE), and injections from 01/28/02 through 06/24/02 were requested.

Decision

It is determined that the physical therapy sessions, office visits, FCE's, and injections from 01/28/02 through 06/24/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient had soft tissue injuries which were treated. She was released back to work until she saw a different physician and underwent additional testing and treatments that were not medically indicated. The MRI performed on 02/14/02 revealed only minor abnormalities and, besides some loss of strength, the documentation does not reveal any other significant deficits or abnormalities.

Therefore, the physical therapy sessions, office visits, FCE's, and injections from 01/28/02 through 06/24/02 were not medically necessary.

Sincerely,