

MDR Tracking Number: M5-03-0978-01

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 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. This dispute was received on 12-16-02.

The IRO reviewed physical therapy and office visits rendered from 2-28-02 to 7-18-02 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 all services rendered were medically necessary, except for 99213 rendered on 4-23-02.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees. 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.

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 June 18, 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 | MARS (Maximum Allowable Reimbursement) | Reference | Rationale |
|---------|----------|---------|--------|-----------------|--|------------------------------|--|
| 2-28-02 | A4556 | \$30.00 | \$0.00 | G | DOP | General Instructions GR (IV) | On this date the requestor billed for electrical stimulation as well as the electrodes. A review of the progress note does not support that these electrodes were provided those above those usually included in the electrical stimulation. |
| TOTAL | | | | | | | The requestor is not entitled to reimbursement. |

This Decision is hereby issued this 15th day of September 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 2-28-02 through 7-18-02 in this dispute.

This Order is hereby issued this 15th day of September 2003.

Roy Lewis, Supervisor
 Medical Dispute Resolution
 Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 6, 2003

Re: IRO Case # M5-03-0978

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 is a 36-year-old male who was injured on ___ when he fell getting off a fork lift. He felt immediate pain in his left buttock that radiated down his left leg and foot. The patient continued to work, and sought medical care on ___. He was started on physical therapy and was prescribed medication. He was treated with mostly passive modalities for one month, and a few days of active exercises. An MRI of the lumbar spine on 12/18/01 showed significant central disk herniation at L5-S1 with moderate impingement. EMG/NCS on 2/18/02 was significant for left L5 radiculopathy. On 2/26/02 a neurosurgeon recommended physical therapy, and it was started on 2/27/02 with both passive modalities and active exercises. After eight weeks of physical therapy, the physical therapist noted that the patient was progressing in mobility, strength, function and pain control. Another four weeks of physical therapy were recommended at that time. Physical therapy continued for another seven weeks. The patient was evaluated in a Designated Doctor Exam on 4/16/02 and was found to not be at MMI, due to the nature of the injury. He was reevaluated on 9/5/02 and was then rated at MMI.

Requested Service(s)

PT one area, mechanical traction, electrical stimulation, therapeutic exercise, MP outpatient visit, 2/28/02 – 6/17/02.

Decision

I disagree with the carrier's decision to deny almost all of the requested treatment except for code 99213 on 4/25/02

Rationale

The patient injured his low back on _____. He was initially treated only with medication and passive modalities, and very little active physical therapy. He was documented to have a herniated L5-S1 disk with left L5 radiculopathy. A neurosurgeon recommended physical therapy, which began 2/27/02. The physical therapist's progress notes document improvement between the start of physical therapy and the halfway point on 4/25/02. The patient is documented as having increased range of motion, strength, flexibility, and less muscle spasm in his low back. On completion of another eight weeks of physical therapy his range of motion, strength, and flexibility continued to improve as well as the low back spasms.

No documentation was presented for this review to support code 99213 on 4/25/02.

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

Sincerely,
