

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 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 12-23-02.

The IRO reviewed physical therapy rendered from 4-30-02 through 9-30-02 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 April 2, 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:

Neither party submitted audit summaries for services identified as "No EOB"; therefore, these will be reviewed in accordance with the Commission's *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
3-20-02	99205	\$137.00	\$0.00	N	\$137.00	Rule 133.307(g)(3)	The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.
3-27-02	99214	\$85.00	\$0.00	N	\$71.00		
4-1-02	97010	\$11.00	\$0.00	F	\$11.00		
4-3-02							
4-8-02							
4-10-02							
4-3-02	97035	\$22.00	\$0.00	C	\$22.00		
4-8-02	97014	\$15.00	\$0.00	F	\$15.00		

4-12-02 4-17-02 4-22-02 4-26-02	97010	\$39.00	\$0.00	F	\$11.00		
4-19-02	97014	\$39.00	\$0.00	F	\$15.00		
4-15-02	89214	\$85.00	\$0.00	No EOB	Unrecognized code	Rule 133.307(g)(3)	The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.
4-19-02	A4556	\$15.00	\$15.00	G	DOP		
4-24-02	97124	\$39.00	\$0.00	F	\$28.00 / 15 min		
5-6-02	99210	\$85.00	\$0.00	No EOB	Unrecognized code		
5-8-02	97035	\$20.00	\$0.00	No EOB	\$22.00 or less	CPT Code Description	SOAP note supports ultrasound; reimbursement of \$20.00 is recommended.
5-8-02	97010	\$20.00	\$0.00	No EOB	\$11.00	CPT Code Description	SOAP note supports hot/cold packs, reimbursement of \$11.00 is recommended.
5-8-02	97014	\$39.00	\$0.00	No EOB	\$15.00	CPT Code Description	SOAP note supports electric stimulation; reimbursement of \$15.00 is recommended.
5-8-02 5-16-02	97124	\$39.00	\$0.00	No EOB	\$28.00/ 15 min	CPT Code Description	SOAP note supports massage; reimbursement of 2 dates X \$28.00 = \$56.00 is recommended.
5-29-02 5-31-02 6-3-02 6-6-02 6-7-02 6-11-02 6-12-02 6-14-02 7-16-02 7-17-02 7-19-02 7-23-02 7-25-02 7-26-02 7-30-02 8-1-02 8-5-02	97530	\$86.00	\$0.00	D	\$35.00 / 15 min	CPT Code Description	The original EOBs were not submitted, and it is unclear what "D" is duplicate of. The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.
5-29-02 5-31-02 6-3-02 6-6-02 6-7-02 6-11-02 6-12-02 6-14-02 7-16-02 7-17-02 7-19-02	97521	\$60.00	\$0.00	D	\$9.00 / 15 min	CPT Code Description	The original EOBs were not submitted, and it is unclear what "D" is duplicate of. The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.

7-23-02 7-25-02 7-26-02							
5-29-02 5-31-02 6-3-02 6-6-02 6-7-02 7-23-02 7-25-02 7-26-02 7-30-02 8-1-02 8-5-02	97250	\$43.00	\$0.00	D	\$43.00	CPT Code Description	The original EOBs were not submitted, and it is unclear what "D" is duplicate of. The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.
5-29-02 5-31-02 6-3-02 6-11-02 6-12-02 6-14-02 7-16-02 7-17-02 7-19-02 7-23-02 7-26-02 7-30-02 8-1-02	97265	\$43.00	\$0.00	D	\$43.00	CPT Code Description	The original EOBs were not submitted, and it is unclear what "D" is duplicate of. The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.
7-16-02 7-17-02 7-19-02	97140	\$43.00	\$0.00	D	Unrecognized code	CPT Code Description	The original EOBs were not submitted, and it is unclear what "D" is duplicate of. The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.
7-25-02	A4556	\$15.00	\$0.00	D	DOP	CPT Code Description	The original EOBs were not submitted, and it is unclear what "D" is duplicate of. The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.
7-30-02 8-1-02 8-5-02	97110	\$78.00	\$0.00	D	\$35.00 / 15 min	CPT Code Description	The original EOBs were not submitted, and it is unclear what "D" is duplicate of. The requestor did not submit medical record to support service billed; therefore, no

							reimbursement is recommended.
8-5-02	97035	\$20.00	\$0.00	D	\$22.00 or less	CPT Code Description	The original EOBs were not submitted, and it is unclear what "D" is duplicate of. The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.
9-24-02	97250	\$43.00	\$0.00	No EOB	\$43.00	CPT Code Description	The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.
9-24-02	97530	\$86.00	\$0.00	No EOB	\$35.00	CPT Code Description	The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.
9-24-02	97110	\$78.00	\$0.00	No EOB	\$35.00 / 15 min	CPT Code Description	The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.
9-30-02	97250	\$43.00	\$0.00	C	\$43.00	CPT Code Description	Medical dispute resolution does not have jurisdiction to address contract disputes; the services in dispute will be reviewed in accordance with the MFG. The requestor submitted SOAP record that supports myofascial release and joint mobilization; therefore, reimbursement is recommended of \$43.00 + \$43.00 = \$86.00.
9-30-02	97265	\$43.00	\$0.00	C	\$43.00		
9-30-02	97530	\$86.00	\$0.00	F	\$35.00 / 15 min X 2 = \$70.00	CPT Code Description	The requestor submitted SOAP record that supports therapeutic activities; therefore, reimbursement is recommended of \$70.00.
10-18-02	99245	\$250.00	\$0.00	N	\$201.00	CPT Code Description	The requestor did not submit medical record to support service billed; therefore, no reimbursement is recommended.
TOTAL							The requestor is entitled to reimbursement of \$258.00 .

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 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 3-20-02 through 10-18-02 in this dispute.

This Order is hereby issued this 7th day of October 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 25, 2003

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

RE:
MDR Tracking #: M5-03-1061-01
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 orthopedic surgeon/physician reviewer who is board certified in orthopedic surgery. The orthopedic surgeon/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

Twenty-three (23) year old male sustained injury on ___ to right thoracolumbar area, pain was delayed in onset did not occur immediately on lifting refrigerator into truck. The first clinical

note I have to review is from 03/29/02 and is an exam by _____. He describes right sided tenderness at level 11-12 ribs on right. He had full lumbar motion and strength without complaint, normal straight leg raising and normal neurologic exam. Diagnosis is thoracolumbar strain. His pain drawing on 04/03/02 is consistent with that complaint. On July 3, 2002, _____ finds no muscle spasm and normal strength and sensation and full lumbar and cervical motion. Subsequent MRI finds only changes at L4 and L5 levels. EMG is normal. Physical therapy is mostly for right thoracic region. Some time subsequent to this time frame, other complaints develop.

Requested Service(s)

Necessity of physical therapy from 04/30/02 - 09/30/02.

Decision

I agree with insurance carrier these services marked U are unnecessary.

Rationale/Basis for Decision

The therapy sheets indicate no significant therapeutic benefit from ongoing therapy. There is no mention of home exercise program or teaching fitness program. Clinical notes from pain

management deal with low lumbar complaints which are not related to original injury. MRI findings would not cause symptoms consistent with right sided thoracic pain. There is no documentation in the physical therapy notes that supports significant change in his clinical course that would support ongoing therapy.

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 TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 25 th day of March 2003.
--