MDR Tracking Number: M5-03-2176-01

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 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 05-01-03.

The IRO reviewed office visits, unlisted procedure, kinetic activities, joint mobilization, physical medicine treatment, lumbar paravertebral regional nerve blocks, DRX treatments rendered 05-09-02, 05-23-02, 06-20-02 through 11-20-02 and 01-09-03 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 for office visits, unlisted procedure, kinetic activities, joint mobilization, physical medicine treatment, lumbar paravertebral regional nerve blocks, DRX treatments. 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 10-09-03, 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	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
05-03-02	64442	$314.00	0.00	U	$155.00	MFG SGR (I)(E)(4)	Services were preauthorized by carrier certification# 010952301. In accordance with 134.600 (b)(1)(B) Recommended reimbursement $155.00
05-03-02	64443	$314.00	0.00	U	$111.00		Services were preauthorized by carrier certification# 010952301. In accordance with 134.600 (b)(1)(B) Recommended reimbursement $111.00

05-03-02	64443	$314.00	0.00	U	$111.00		Services were preauthorized by carrier certification# 010952301. In accordance with 134.600 (b)(1)(B) Recommended reimbursement $111.00
05-17-02	64442	$314.00	0.00	V	$155.00		Services were preauthorized by carrier certification# 010952302. In accordance with 134.600 (b)(1)(B) Recommended reimbursement $155.00
05-17-02	64443	$314.00	0.00	V	$111.00		Services were preauthorized by carrier certification# 010952302. In accordance with 134.600 (b)(1)(B) Recommended reimbursement $111.00
05-17-02	64443	$314.00	0.00	V	$111.00		Services were preauthorized by carrier certification# 010952302. In accordance with 134.600 (b)(1)(B) Recommended reimbursement $111.00
05-31-02	64442	$314.00	0.00	U	$155.00		Services were preauthorized by carrier certification# 010952303. In accordance with 134.600 (b)(1)(B) Recommended reimbursement $155.00
05-31-02	64443	$314.00	0.00	U	$111.00		Services were preauthorized by carrier certification# 010952303. In accordance with 134.600 (b)(1)(B) Recommended reimbursement $111.00
05-31-02	64443	$314.00	0.00	U	$111.00		Services were preauthorized by carrier certification# 010952303. In accordance with 134.600 (b)(1)(B) Recommended reimbursement $111.00
10-30-02	64442	$314.00	0.00	V	$155.00		In accordance with 133.301(b)(1) an Insurance carrier can not change a billing code without contacting the sender of the bill. Carrier audited services with a modifier 50. In addition services were preauthorized by

							carrier certification# 011896801. In accordance with 134.600 (b)(1)(B) Recommended reimbursement $155.00
10-30-02	64443	$314.00	0.00	V	$111.00		In accordance with 133.301(b)(1) an Insurance carrier cannot change a billing code without contacting the sender of the bill. Carrier audited services with a modifier 50. In addition services were preauthorized by carrier certification# 011896801. In accordance with 134.600 (b)(1)(B) Recommended reimbursement $111.00
10-30-02	64443	$314.00	0.00	V	$111.00		In accordance with 133.301(b)(1) an Insurance carrier cannot change a billing code without contacting the sender of the bill. Carrier audited services with a modifier 50. In addition services were preauthorized by carrier certification# 011896801. In accordance with 134.600 (b)(1)(B) Recommended reimbursement $111.00
TOTAL		$3768.00					The requestor is entitled to reimbursement of **$** 1663.00

This Decision is hereby issued this 10th day of May 2004.

Georgina Rodriguez
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 05-03-02, 05-17-02, 05-31-02 and 10-30-02 in this dispute.

This Order is hereby issued this 10th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION amended 4/12/04, 4/23/04, 5/3/04

October 3, 2003

MDR # M5-03-2176-01

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 physcian who is Board Certified in Physical Medicine and Rehabilitation , and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. 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 her low back on ___. She underwent laminectomy and diskectomy, but records were not provided regarding those procedures or early treatment of the patient. A CT myelogram on 11/14/99 was significant for right paricentral disk herniation at L5-S1. On 5/3/02 the patient underwent bilateral facet injections at L2-3, L3-4, and L4-5. On 5/17/02 and 5/31/02 bilateral facet injections were performed at L3-4, L4-5 and L5-S1. The patient was also treated with regional paravertebral regional nerve blocks, and a series of 20 DRX treatments.

Requested Service(s)
Office visits, unlisted procedure, hot or cold packs 5/9/02, 5/23/02, 6/20/02-11/20/02, 1/9/03

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

Rationale
The medical records provided for this review do not document the medical necessity for the requested treatments/services. The records provided do not document the efficacy of any of the treatments or indicate any kind of objective or subjective benefit.

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

Sincerely,