THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-1167.M5

MDR Tracking Number: M5-03-2747-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on November 18, 2002.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevailed** on the majority of the medical necessity issues: **prevailing charges total: $1,335.00, non-prevailing charges total: $2,248.00.** Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits (CPT codes 99213 and 99203), and electrical stimulation (CPT code 97014) **were found to be medically necessary**. The therapeutic activities (one-to-one), massage, vasopneumatic device, therapeutic exercises, office visits (CPT code 99212) **were not found to be medically necessary.** The respondent raised no other reasons for denying reimbursement of office visits (CPT codes 99213 and 99203), and electrical stimulation (CPT code 97014), therapeutic activities (one-to-one), massage, vasopneumatic device, therapeutic exercises, office visits (CPT code 99212) charges

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 Order is applicable to dates of service 8/7/02 through 10/2/02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 30th day of September 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION

September 12, 2003

Re: IRO Case # M5-03-2747-01, Amended

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, 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 lower back on ___ when she slipped and fell. She was treated with medication and physical therapy from 4/1/02 – 7/24/02 with poor results. She changed to a different treating doctor as of 7/19/02.

Requested Service(s)
Office consultation, office visit, physical therapy 8/7/02 – 10/2/02

Decision

I agree with the carrier's decision to deny the requested treatment, except for CPT Code 99203, 99213, and 97014.

I disagree with the decision to deny CPT codes 97014, 99203, and 99213 for each date of service.

Rationale

The patient had an extensive trial of physical therapy which failed prior to the dates of the treatment in dispute. The records provided for this review describe using therapeutic activities while treating the patient, but no documentation was provided on what activities were used, and no results from the use of these activities was provided. From the records provided for this review it appears that a home-based exercise program would have been appropriate for this patient.

The documentation does not support the use of a vasopneumatic device. The documentation regarding massage therapy fails to describe the type of massage used, and based on the records provided, it's benefit to this patient would be questinable.

Electrical stimulation (97014), however, was necessary to decrease pain and spasms. CPT codes 99203 and 99213 were necessary for evaluation and for use of manipulation of the lumbar spine, which based on the records provided, was most useful to the patient. The documentation relating to orthopedic tests, ranges of motion and muscle spasm supported the necessity of spinal manipulation. The patient's pain scale was 7-8/10 on 8/28/02 and 3-4/10 on 10/2/02. She was able to return to work without restrictions.

The use of manipulation of the lumbar spine and electrical stimulation was reasonable and effective in relieving symptoms.

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

Sincerely,

_____