MDR Tracking Number: M5-03-2813-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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 07-02-03.

The IRO reviewed myofasical release, data analysis, office visits, range of motion testing, aquatic therapy, joint mobilization, special reports, manual traction, gait training, LSO flexible elastic type, physical performance test, and massage therapy rendered from 08-05-02 through 10-15-02, 10-22-02 through 04-14-03 and 04-21-03 through 05-12-03 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 myofasical release, data analysis, office visits, range of motion testing, aquatic therapy, joint mobilization, special reports, manual traction, gait training, LSO flexible elastic type, physical performance test, and massage therapy. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 September 4, 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	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
10-21-02	97113 (3 units)	$165.00	0.00	No EOB	$52.00	133.307 (g)(3)	Soap notes support delivery of service. Recommended Reimbursement $ $156.00
	99213	$51.00	0.00		$48.00	133.307 (g)(3)	Soap notes support delivery of service. Recommended Reimbursement $ 48.00
04-17-03	99213	$51.00	0.00		$48.00	133.307 (g)(3)	Soap notes support delivery of service. Recommended Reimbursement $ 48.00
TOTAL		$267.00					The requestor is entitled to reimbursement of **$ 252.00**

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 10-21-02 and 04-17-02 in this dispute.

This Decision is hereby issued this 6th day of February 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

August 20, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-03-2813-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ injured his low back on ___ while carrying glasses and dishes at work. No treatment notes were provided for services rendered prior to June of 2002, but multiple diagnostic studies were done. On 8/14/01 an MRI showed an annual injury of L3/4 and posterior disc bulges at L4/5 and L5/S1 with slight effacement of the thecal sac. On 12/4/01 an evoked potential study noted an abnormal findings suggesting a L1 radiculopathy. On 2/20/02 a CT showed a grade III nuclear degenerative change at L5/S1, at L4/5 a grade V degeneration of the nucleus with a 4-5 mm focal

disc protrusion/extrusion contacting and deforming the ventral dura, and a grade IV degeneration of the L3/4 IVD. The patient was treated by IDET on 6/19/02 and again on 10/30/02, and bilateral SI joint radiofrequency neurotomy on 1/8/03. The patient was also treated with physical therapy.

DISPUTED SERVICES

Under dispute is the medical necessity of myofascial release, data analysis, office visits, range of motion testing, aquatic therapy, joint mobilization, special reports, manual traction, gait training, LSO: flexible, elastic type, physical performance test and massage therapy for DOS 8/5/02-10/15/02, 10/22/02-4/14/03, and 4/21/03-5/12/03.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient was given extended passive and active therapy upon referral. The procedures and dates in dispute are those where the therapy was performed from 8/5/02-10/15/02, 10/22/02-4/14/03, and 4/21/03-5/12/03. While the therapy was performed because of the surgeon's and other evaluating doctors recommendations, it is incumbent upon the facility performing the therapy to show effectiveness of the therapy. Unfortunately, throughout the entire history of the patient's therapy treatment, the notes showed virtually no change in the patient's condition. His reported subjective symptoms remained static and there was very little clue in the daily notes that he changes objectively. As there is no proof in the notes that the therapy was effective, the ___ reviewer does not find medical necessity for the services in dispute.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,