MDR Tracking Number: M5-03-2878-01

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. The dispute was received on 7/7/03.

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(r)(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.

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 in addition to medical necessity issues, there were fee guideline issues to be resolved. The office visits, electrical stimulation, ultrasound, therapeutic exercises, therapeutic activities and exercises, neuromuscular re-education and hot or cold packs from 9/3/02 through 10/10/02 were found to be medically necessary. The office visits, electrical stimulation, ultrasound, therapeutic exercises, therapeutic activities and exercises, neuromuscular re-education and hot or cold packs after from 10/28/02 through 12/27/02 were found not medically necessary.

In addition, the office visit 99214 of 9/30/02 and special supplies 99070-PH of 10/11/02 were denied based upon "N" lack of documentation. The medical report 99080-73 of 11/19/02 was denied on the basis of "F" medical fee guideline.

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
9/3/02 through 10/11/02	99212 x 7 units	$37.00 per unit	0.00	U	$32.00 per unit	§133.1(a)(8) IRO decision	The IRO determination is that these disputed services are medically necessary. Reimbursement of $224.00 is recommended.
	97014 x 6 units	$15.00 per unit	0.00	U	$15.00 per unit	See above.	See above. Reimbursement of $90.00 is recommended.
	97035 x 7 units	$28.00 per unit	0.00	U	$22.00 per unit	See above.	See above. Reimbursement of $154.00 is recommended.
	97110 x 28 units	$30.00 per unit	0.00	U	$30.00 per unit	See above.	See above. Reimbursement of $840.00 is recommended.

	97530 x 14 units	$41.00 per unit	0.00	U	$35.00 per unit	See above.	See above. Reimbursement of $490.00 is recommended.
	97112 x 2 units	$42.00 per unit	0.00	U	$35.00 per unit	See above.	See above. Reimbursement of $70.00 is recommended.
10/28/02 through 12/27/02	99212 x 5	$37.00 per unit	0.00	U	$32.00 per unit	§133.1(a)(8) IRO decision	The IRO determination is that these disputed services are not medically necessary and therefore should not be reimbursed.
	99214 x 1	$71.00 per unit	0.00	U	$71.00 per unit	See above.	See above. Reimbursement is not recommended.
	97014 x 5	$15.00 per unit	0.00	U	$15.00 per unit	See above.	See above. Reimbursement is not recommended.
	97035 x 3	$28.00 per unit	0.00	U	$22.00 per unit	See above.	See above. Reimbursement is not recommended.
	97110 x 10	$30.00 per unit	0.00	U	$30.00 per unit	See above.	See above. Reimbursement is not recommended.
	97112 x 4	$41.00 per unit	0.00	U	$35.00 per unit	See above.	See above. Reimbursement is not recommended.
9/30/02	99214 x 1	71.00 per unit	0.00	N	$71.00 per unit	The MFG CPT code descriptor.	The medical documentation for this date of service supports delivery of this service. Reimbursement of $71.00 is recommended.
10/11/02	99070-PH	21.00 per unit	0.00	N	DOP	MFG General Instructions (III)(A)	See above. Reimbursement of $21.00 is recommended.
11/19/02	99080-73	15.00 per unit	0.00	F	DOP	See above.	A medical report for this date of service was submitted by the requestor verifying delivery of service. Reimbursement of $15.00 is recommended.
TOTAL							The requestor is entitled to reimbursement of **$1,975.00.**

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees ($1,975.00). Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay $1,975.00 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 9/3/02 through 10/11/02 and 9/30/02 through 11/19/02 in this dispute.

This Order is hereby issued this 13th day of January 2004.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/nlb

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

November 4, 2003

Re: IRO Case # M5-03-2878

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, 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 is a 37-year-old male who slipped on a wet floor, landing on his buttocks. He immediately felt pain in his neck and groin. An MRI on 7/27/02 was significant for bilateral spondylolysis at L5-S1 with grade I anteriolisthesis. The patient was evaluated by an M.D. on 8/6/02 and began treatment with a D.C. on 8/15/02. He was referred for a surgical evaluation on 8/27/02. Continued conservative treatment was recommended, and the patient also underwent electrodiagnostic testing on 8/30/02. Needle EMG and NCS were normal. Somatosensory evoked potentials and lower extremity dermatomal evoked potentials suggested possible L4 radiculopathy. The patient began physical therapy on 9/3/02 and was given an epidural steroid injection on 9/19/02. A Designated Doctor Examination took place on 10/4/02 and a bone scan was ordered, and was read as negative. Lumbar surgery was performed on 12/11/02.

Requested Service(s)
Office visits, electrical stimulation, ultrasound, therapeutic exercises, therapeutic activities & exercises, neuromuscular re education, hot or cold packs 9/3/02-12/27/02.

Decision
I disagree with the carrier's decision to deny the requested treatment 9/3/02-10/11/02.
I agree with the decision to deny the requested treatment after 10/11/02.

Rational
The patient suffered a traumatic injury to his neck and low back. Following multiple medical and chiropractic evaluations and diagnostic workup, he eventually began physical therapy on 9/3/02. This continued 2-3 times per week through 10/11/02. During that period the patient missed one week. This treatment was part of additional conservative management of acute cervical and lumbar injuries and was medically necessary.
After 10/11/02, the patient again had physical therapy on 10/28/02. Treatment was inconsistent and averaged once every three weeks. No documentation was provided that showed the medical necessity of this inconsistent and sporadic patient attendance and treatment. Following surgery on 12/11/02 the patient was seen by the D.C. on 12/23/02 and 12/27/02,but at that time the patient was not yet ready to begin post operative physical therapy.

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