

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-04-4212.M5

MDR Tracking Number: M5-03-3070-01

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, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 7-25-03.

The IRO reviewed office visits, therapeutic activities, hot/cold packs, and electrical stimulation rendered from 7-25-02 through 10-25-02.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO concluded that only four units of therapeutic activities per visit, the office visits, and the hot/cold packs from 7-25-02 through 10-25-02 were medically necessary. The IRO agreed with the previous determination that electrical stimulation from 7-25-02 through 10-25-02 were **not** medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. The disputed dates of service 7-8-02 and 7-10-02 are untimely and not eligible for review per TWCC Rule 133.307 (d)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute. The Commission received the medical dispute on 7-25-03.

On September 24, 2003, the Medical Review Division submitted a Notice to the 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
8-2-02	97032	\$22.00	\$0.00	F	\$22.00	96 MFG Med GR, CPT descriptor, Rule 133.307(g)(3)	Daily notes support delivery of service. Recommend reimbursement of \$22.00x 3 = \$66.00.
8-5-02	97032	\$22.00X2	\$0.00	N			
8-8-02							
10/11/02	95900-27 95904-27 95935-27 F study 95935-27 H study	\$400.00(4) \$365.00(6) \$400.00(4) \$200.00(2) \$330.00(2)	\$104.90 \$179.20 \$ 90.10 \$165.00	O	\$64.00 ea motor nerve \$64.00 ea sensory nerve \$53.00 per study (F max 4 units (upper & lower), H max 2 units (lower only)) \$175.00 one or	96 MFG Med GR IV; CPT descriptors; Rule 133.307(g)(3)	Lower Extremity Nerve Conduction Report supports delivery of these services. Recommend reimbursement as follows: \$64.00 x 4 = \$256.00 x 70% = \$179.00 -\$104.90 = \$74.10. \$64.00 x 6 = \$384.00 x 70% = \$269.00 -\$179.20 = \$89.80. F study. Documentation supports study on two extremities. Per Rule comparison study is not

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
	95925-27-D				more nerves (tech comp (-27) reimb @ 70%)		reimbursable. H study. Documentation supports two studies per Rule. Therefore, for H & F reflex studies, recommend reimbursement of \$53.00 x 3 = \$159.00 x 70% = \$111.00 - \$90.10 = <u>\$20.90.</u> Somatosensory testing is reimbursed \$175.00 regardless the number of nerves. No additional reimbursement is recommended.
TOTAL		\$6,516.00	\$539.00				The requestor is entitled to reimbursement of \$250.80.

The above Findings and Decision are hereby issued this 3rd day of February 2004.

Dee Z. Torres
 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 Order is applicable for dates of service 7-25-02 through 10-25-02 in this dispute.

This Order is hereby issued this 3rd day of February 2004.

Roy Lewis, Supervisor
 Medical Dispute Resolution
 Medical Review Division

RL/dz

January 30, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter**

MDR Tracking #: M5-03-3070-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 37 year-old male who sustained a work related injury on ___. The patient reported that while at work he fell while carrying a piece of steel. On 6/6/00 the patient underwent an MRI of the lumbar spine that showed a 2mm shallow bulged disc at T12-L1, 4mm diffuse disc at L4-L5 and Grade I spondylolisthesis of L5 and S1 with spondylolysis at L5 bilaterally with diffuse posterior pseudo-disc with severe hypertrophic facet arthropathies bilaterally at L5-S1. The patient has also undergone a myelogram and X-Rays of his lumbar spine. The patient underwent a lumbar fusion on 2/22/02. Post surgically the patient underwent a lower extremity nerve conduction test that was reported to be normal. The patient was then treated with postoperative rehabilitation from 7/25/02 through 10/25/02.

Requested Services

Office visits, therapeutic activities, hot or cold packs, electrical stimulation from 7/25/02 through 10/25/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 37 year-old male who sustained a work related injury to his back on ____. The ___ chiropractor reviewer also noted that the patient underwent a lumbar fusion on 2/22/02. The ___ chiropractor reviewer further noted that the patient was treated postoperatively with rehabilitation from 7/25/02 through 10/25/02. The ___ chiropractor reviewer explained that the patient was referred for physical therapy initially after he fell. The ___ chiropractor reviewer also explained that the patient's back had healed well enough after surgery to start a rehabilitation program. The ___ chiropractor reviewer indicated that the rehabilitation program was medically necessary and was aimed at facilitating a return to work for this patient.

However, the ___ physician reviewer explained that the patient has had extensive therapy in the past and should be experienced in home therapy. The ___ chiropractor reviewer also explained that 4 units of supervised therapy per visit were medically necessary to treat this patient's condition. The ___ chiropractor reviewer further explained that the patient could have performed the walking portion of his rehabilitation on his own. Therefore, the ___ chiropractor consultant concluded that 4 units of therapeutic activities per visit from 7/25/02 through 10/25/02 were medically necessary to treat this patient's condition. The ___ chiropractor consultant also concluded that the electrical stimulation from 7/25/02 through 10/25/02 were not medically necessary to treat this patient's condition. However, the ___ chiropractor consultant further concluded that the office visits and hot or cold packs from 7/25/02 through 10/25/02 were medically necessary to treat this patient's condition.

Sincerely,