

MDR Tracking Number: M5-03-3208-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 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 8-8-03.

The IRO reviewed office visits, hot/cold packs, ultrasound, joint mobilization, electrical stimulation, neuromuscular reeducation, required reports, myofascial release, massage, gait training, and therapeutic activities from 9-23-02 to 10-21-02.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. 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 \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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.

On 10-22-03, 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	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
8/27/02	A4556	\$85.00	\$0.00	G	DOP	96 MFG DME GR; Rule 133.307(g)(3) (A-F)	Electrodes are not global; however, no documentation was submitted to support delivery of service. No reimbursement recommended.
1028/02 10/30/02	97014 97035 97265(2) 97124 97032 97010 97112	\$15.00 \$22.00 \$43.00(2) \$28.00 \$22.00 \$11.00 \$35.00	\$0.00	F, TK	\$15.00 \$22.00 ea 15 min \$43.00 \$28.00 \$22.00 ea 15 min \$11.00 \$35.00 ea 15 min	Rule 133.307(g)(3) (A-F)	Legible or relevant information submitted for review does not support delivery of services billed. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
TOTAL		\$304.00	0.00				The requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 2nd day of March 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 Decision is applicable for dates of service 9-23-02 through 10-21-02 in this dispute.

This Order is hereby issued this 2nd day of March 2004.

Roy Lewis, Supervisor
 Medical Dispute Resolution
 Medical Review Division

February 16, 2004

Rosalinda Lopez
 Texas Workers' Compensation Commission
 Medical Dispute Resolution
 Fax: (512) 804-4868

REVISED REPORT
Revised dates of dispute.

Re: MDR #: M5-03-3208-01
 IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:

The patient was injured on the job on ___. He has undergone passive and active therapies, epidural steroid injections, work hardening, acupuncture, chiropractic care, trigger-point therapy, bilateral lumbar facetotomy, foraminotomy, and laminectomy and discectomy fusion. Surgery was

performed on 08/14/02. He has also taken prescriptions for depression and anxiety. He is still in constant pain in his lower back and is experiencing negative emotional feedback due to the injury. He is sleeping poorly and has difficulty dealing with his condition.

Disputed Services:

Denial of office visits, electrical stimulation, ultrasound, joint mobilization, massage therapy, gait training therapy, hot and cold packs, medical report, myofascial release, neuromuscular re-education, and therapeutic exercises from 09/23/02 through 10/21/02.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The services in question were medically necessary in this case.

Rationale:

The reviewer's opinion is based on *Spinal Treatment Guidelines*, according to which the patient would fall into the primary level of care. This treatment protocol is assigned due to his postoperative condition following the surgery done on 08/14/02. Early postoperative care included physical modalities/therapeutic exercises, ice/heat, massage, joint mobilization, and muscle re-education. This phase of care can last up to eight weeks. Because the patient had shown slight improvement during the time of receiving this care, and did show a positive progression in the treatment protocol, it is reasonable for the treating doctor to continue with this protocol, at least up to eight weeks postoperatively. This case falls into these parameters.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,