MDR Tracking Number: M5-03-1905-01

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 4-1-03.

The IRO reviewed office visits, physical medicine sessions, supplies, and patient education materials rendered from 10-17-02 through 1-24-03.

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.

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 August 7, 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
8-27-02 8-28-02 8-29-02	99204 97124 97010 97014 97035	120.00 45.00x3 26.00x3 20.00x3 25.00x3	0.00	L	106.00 28.00 ea 15 min 11.00 15.00 22.00 ea 15 min	96 MFG E/M GR I C; VI A; Med GR I A 10 a	The requestor was not the treating doctor of record until 10-16-02 per the approved TWCC-53; therefore, no reimbursement can be recommended.
1-23-03	99455-RP	50.00	0.00	F	50.00	96 MFG E/M XXII	Requestor submitted relevant information to support services rendered. Recommend reimbursement of $50.00.
TOTAL		518.00					The requestor is entitled to reimbursement of $50.00.

This Decision is hereby issued this 12th day of January 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 10-17-02 through 1-24-03 in this dispute.

This Order is hereby issued this 12th day of January 2004.

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

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 22, 2003

RE: MDR Tracking #: M5-03-1905-01
IRO Certificate #: **5242**

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer. The Chiropractic physician reviewer has signed a certification statement stating 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 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 this case.

Clinical History
According to the documentation supplied, it appears that the claiamnt fell off of a ladder while at work on ___. He sustained an injury to his left wrist and to his lumbar spine. The claimant received treatment from somewhere, but the documentation supplied does not tell from whom. The claimant had surgery to his wrist where he received pins and casting for support. After 4-6 weeks the pins were removed and after 2 months the cast was removed. The claimant reported to ___ for treatment on 08/27/2002. ____ was told he was not the treating doctor, so he discontinued care until 10/27/2002 when he began an active chiropractic therapy program. The claimant had a MRI performed on 10/23/2002 that revealed a 2.5 mm

disc bugle at L3-4 with osteophytes and a 1.5 mm disc bulge at L4-5. On 10/24/2002, ___ examined the claimant and determined that the claimant should continue with his rehabilitation.

The claimant continued his active therapy with ___. The claimant was later referred to ___ for evaluation of his low back pain. ___ performed a lumbar epidural steroid injection on 01/14/2003. A functional capacity exam was performed on the claimant on 01/30/2003, which revealed that he was at a light medium level. The claimant was subsequently entered into a work hardening program. The documentation ends here.

Requested Service(s)
Please review and address the medical necessity of the outpatient services including office visits, supplies, and patient education materials rendered between 10/17/2002 through 01/24/2003.

Decision
I disagree with the insurance company that monthly office visits, including therapy were medically necessary from 10/17/2002 – 01/24/2003. I agree with the insurance company that the supplies and patient education material were not medically necessary. I also agree that office visits exceeding one per month were also not medically necessary.

Rationale/Basis for Decision
The claimant underwent surgery with for his wrist injury shortly after his accident. After the fracture had healed it would be clinically warranted for a full active rehabilitation for his injury. The claimant was referred for an evaluation for his hand injury. ___, a hand specialist, concurred with the active rehabilitation protocol that ___ was utilizing. After eight weeks the claimant had significant recovery, but wasn't at maximum medical improvement. ___, who felt that the active rehab should continue, again evaluated the claimant. Since a specialist who recommended the care during the dates in question evaluated the claimant, it shows medical necessity for the therapy rendered. The documentation did not show any prior treatment to the claimant's lumbar spine issues. An eight-week active rehabilitation would also be warranted for his injuries sustained. At the end of the program, the claimant was evaluated by ___, who performed an epidural steroid injection. After the injection, post rehab would also be warranted. After careful review of the entire chart, the overall rehabilitation program that the claimant was subjected to is considered reasonable and medically necessary. The documentation provided no objective support for the patient education material and supplies, therefore no medical necessity was found. The use of evaluation and management codes that exceed one per month is not considered necessary due to the claimant being seen on a very frequent basis during his treatment program. The claimant being evaluated once a month is necessary to monitor the claimant's condition and to change treatments as needed.