MDR Tracking Number: M5-03-1917-01

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 3-31-03.

The IRO reviewed special supplies, therapeutic exercises, office visits, muscle testing, electrical stimulation, myofascial release, joint mobilization, initial medical report, and range of motion rendered on 4-17-02, 4-24-02 through 4-26-02, and 5-7-02 through 7-17-02 that were denied as unnecessary medical.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. 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.

On June 26, 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
4-23-02	99201	40.00	0.00	F	34.00	96 MFG E/M GR IV, C; VI A	The carrier denied as "F – The Medical Fee Guideline states in the importance of proper coding "accurate coding of services rendered is essential for proper reimbursement", the services performed are not reimbursable as billed. Patient Office Visit Report does not support the level of service. The requestor previously billed for a new patient office visit on 4-17-02; therefore, reimbursement cannot be

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
							recommended for the billed code.
5-2-02	99080-73	15.00	0.00	F	15.00	96 MFG Med GR, CPT descriptor, and Rule 129.5.	Relevant information was not submitted to support services rendered. No reimbursement recommended.
5-2-02	95851 97750-MT	40.00 129.00	0.00	G	36.00 43.00 ea body area	96 MFG Med GR	Per carrier's response and documentation, these services were paid by check # 08956078. Per telecon with requestor, payment was received on 8-7-03. Therefore, no further review is required
TOTAL		224.00	0.00				The requestor is not entitled to reimbursement.

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The above Findings and Decision are hereby issued this 13th day of January 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 17, 2003

Re: IRO Case # M5-03-1917-01

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 Doctor of Chiropractic who is licensed by the State of Texas. 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 injured her wrist and hand in ___. She reported the injury to her supervisor on ___ after experiencing pain for several weeks. The patient was evaluated by an MD who conducted an NVC, diagnosed her with right carpal tunnel syndrome, and gave her medication and a wrist brace. The patient then sought chiropractic care.

Requested Service(s)
Special supplies, therapeutic exercises, office visits, muscle testing, electrical stimulation, myofascial release, joint mobilization, initial medical report, range of motion 4/17/02, 4/24-4/26/02, 5/7-7/17/02.

Decision
I agree with the carrier's decision to deny the requested treatment.

Rationale
The patient had received extensive chiropractic treatment without documented relief of her symptoms. On 4/17/02 her pain scale was 6/10. On 7/3/02 her pain scale was 4/10 after almost three months of treatment. On 4/26/02 the patient stated that she could look after herself without extra pain, and her social life is normal and causes no pain, and that she can travel and sleep without pain. These subjective complaints indicate very minor symptoms, and symptom magnification with respect to her pain scale.

On 6/26/02, after two months of treatment, the patient still exhibited severe palpable myofascial trigger points in her right arm, hand and wrist, and abnormally reduced joint motions. The subjective complaints and objective findings, some two to three months after treatment started are signs that treatment failed to be beneficial to the patient. The treating doctors failed to show objective, quantifiable findings to support treatment.
The treatment was extensive, inappropriate and over utilized and resulted in doctor

dependency. The records provided for this review indicate that treatment was not directed at progression for return to work, and was not provided in the least intensive reasonable setting .

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

Sincerely,

_____