THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-04-7321.M5

MDR Tracking Number: M5-03-2686-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 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 06-23-03.

The IRO reviewed aquatic therapy, office visits, electrical stimulation, neuromuscular re-education, myofascial release, joint mobilization, therapeutic exercises, unusual travel and work conditioning rendered from 08-23-02 through 11-27-02 that were denied based "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 09-04-03, 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	MAR$	Reference	Rationale
10-1-02	99215	$108.00 (1 unit)	$0.00	N	$103.00	96 MFG GR(VI)(B)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of $103.00
10-1-02	99080-73	$15.00 (1 unit)	$0.00	F	$15.00	Rule 133.106(f)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended
11-21-02 and 11-22-02	97545-WC	$144.00 (1 unit @ $72.00 X	$0.00	A	$28.80 ($36.00 less 20%	96 MFG MEDICINE GR (II)(C)	A - Preauthorization required for non-CARF providers. Requestor did not

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
(2 DOS)		2 DOS)			reduction for non-CARF provider)		submit proof of preauthorization of services. No reimbursement recommended

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
11-21-02 and 11-22-02 (2 DOS)	97546-WC	$144.00 (2 units @ $72.00 X 2 DOS)	$0.00	A	$28.80 ($36.00 less 20% reduction for non-CARF provider)	96 MFG MEDICINE GR (II)(C)	A - Preauthorization required for non-CARF providers. Requestor did not submit proof of preauthorization of services. No reimbursement recommended
11-25-02	99213	$50.00 (1 unit)	$0.00	F	$48.00	Rule 133.307 (g)(3(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $48.00
TOTAL		$461.00	$0.00				Requestor is entitled to reimbursement in the amount of $151.00

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 10-01-02 and 11-25-02 in this dispute.

This Findings and Decision and Order are hereby issued this 2nd day of June 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

September 3, 2003
Amended March 16, 2004

TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-03-2686-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

This patient suffered a gradual onset of pain in the upper extremity on the left with pain in the hand, thumb and wrist which radiated into her forearm and elbow. She began treating with ___ with chiropractic, passive and active therapies and work hardening. Also included was aquatic therapy. She was seen by a designated doctor, ___ on December 11, 2002 and was found to not be at MMI. Records from the treating doctor are of the travel card variety and do not follow the SOAP format.

DISPUTED SERVICES

Under dispute is the medical necessity of special reports, aquatic therapy, office visits, electrical stimulation, neuromuscular re-education, myofascial release, joint mobilization, therapeutic exercises, unusual travel, and work conditioning.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The notes are not indicative of the patient's progress on this case. While it is possible that the patient could have used aquatic therapy, no reasoning is given by the treating doctor that it was used or the effect it could have. Work hardening seems to be inappropriate in this case at this stage and not documented as to its medical necessity. It is important to remember that this patient had a history of a wrist sprain. While some treatment for such an injury is certainly not out of the ordinary, the treatment's effectiveness and efficiency should be considered by the treating clinic

and the documentation does not clearly demonstrate those considerations. As a result, the reviewer is unable to find the treatment medically necessary.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,