MDR Tracking Number: M5-03-2746-01

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 June 27, 2003.

The IRO reviewed office visits, special reports, myofascial release, group therapy procedure, ultrasound, therapeutic procedure, physician medicine treatment, office visit with manipulations rendered from 10/9/02 through 2/27/03 denied based upon "V".

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 25, 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$	Reference	Rationale
7/10/02	99213	$60.00	$0.00	G	$48.00	MFG, Evaluation/ Management Ground Rule (VI)(B) MFG, Surgery Ground Rule (II)(B)(e)	The global rule is not applicable to the disputed charge. Per MFG, E/M, (VI)(B), the requestor is entitled to reimbursement of the office visit. Reimbursement is recommended in the amount of $48.00.
	29125 Application of short arm splint	$75.00	$0.00	F	$51.00	MFG, Surgery Ground Rule (II)(B)(e)	Review of the evaluation note submitted by the requestor supports delivery of service,

						CPT Code Descriptor	therefore the requestor is entitled to reimbursement in the amount of $51.00.
	29260 strapping-elbow or wrist	$45.00	$0.00	F	$30.00	MFG, Surgery Ground Rule (II)(B)(e) CPT Code Descriptor	Review of the evaluation note submitted by the requestor supports delivery of service, therefore the requestor is entitled to reimbursement in the amount of $30.00.
TOTAL		$180.00	$0.00		$129.00		The requestor is entitled to reimbursement in the amount of $129.00.

This Findings and Decision is hereby issued this 15th day of January 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

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 7/10/02 through 2/27/03 in this dispute.

This Order is hereby issued this 15th day of January 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

August 19, 2003

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

MDR Tracking #: M5-03-2746-01
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

For the past seven years, ___, a 29-year-old employee of___, has worked as a 10-key data input operator. She began suffering from a multitude of injuries arising form repetitive and cumulative stress related to her occupation. In ___ she complained of bilateral wrist and right elbow discomfort. Her diagnosis included bilateral carpal tunnel syndrome, right cubital tunnel syndrome, DeQuervain's on the right and right lateral epicondylitis. Her treatment included several steroid injections, medication, braces, carpal tunnel release and conservative care.

DISPUTED SERVICES

Under dispute is the medical necessity of office visits, special reports, myofascial release, group therapy, ultrasound, therapeutic procedures, physical medicine treatments and office visits with manipulation.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient had several areas that were traumatized by repetitive motion. It appears she responded and improved from the treatment of one area, only to experience increased symptoms in another as she continued to work. From the documentation provided, the reviewer finds that the patient was responding to the treatment that ___ provided and his treatment was reasonable and not excessive. The reviewer also finds that care provided falls within the parameters set forth in the Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters, a TCA Publication, 1994. Office visits, special reports, myofascial release, group therapy, ultrasound, therapeutic procedures, physical medicine treatments and office visits with manipulation were necessary to enhance this patient's ability to return and maintain her position as a productive employee.

___ 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,