

MDR Tracking Number: M5-03-2899-01

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 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 07-11-03.

The IRO reviewed joint mobilization, therapeutic procedures, office visits, range of motion measurement and reports rendered from 03-28-03 through 05-14-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for joint mobilization, therapeutic procedures, office visits, and range of motion measurement and reports. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 08-21-03, 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\$ (Maximum Allowable Reimbursement)	Reference	Rationale
04-08-03	97750MT	\$43.00	0.00	G	\$43.00	MFG MGR (I)(E)(3)	Per Rule MFG MGR (I)(E)(3) Muscle testing is not global to another service billed on same

							day; SOAP notes support the delivery of service. Recommended reimbursement \$43.00	
04-10-03	99080-73	\$15.00	0.00	F	\$15.00	Rule 126.5	Per Rule Work Status Report was not completed and filed in form and manner prescribed by the Commission. No reimbursement recommended.	
04-16-03	95851	\$36.00	0.00	F	\$36.00	MFG MGR (I)(E)(4)	Per Rule Range of motion testing is not considered global to another service billed on same day. SOAP notes support the delivery of service. Recommended reimbursement \$36.00	
TOTAL		\$94.00						The requestor is entitled to reimbursement of \$ 79.00

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 03-28-03 through 05-14-03 in this dispute.

This Decision is hereby issued this 13th day of January 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

August 15, 2003

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An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

Patient treated with physical medicine modalities for left wrist pain after injury on ____.

REQUESTED SERVICE (S)

Physical therapy, office visits, and ROM testing from 3/28/04 – 4/7/03, 4/8/03 – 4/10/03, 4/14/03, and 4/16/03 – 5/14/03.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Other than changing the pain rating from '7' to '5' on 4/22/02 and periodically commenting on referrals, the daily progress notes were almost verbatim for each

and every visit for the dates in question. For that reason, legitimate daily progress notes regarding the patient's treatment and response to care were not furnished. Since the daily progress notes did not meet the proper standard of care, there was no documentation supplied to support the medical necessity for any of the treatments performed.

It is also noteworthy to mention that on the rare occasions that the daily progress notes changed, they were inconsistent. For example, the physician beginning 4/22/02 stated on almost every visit that the patient reported the left wrist was slightly improved. That is completely inconsistent with the patient reporting his pain level at '5' during each and every one of those subsequent visits.