MDR Tracking Number: M5-03-2906-01

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 office visits, office visits with manipulation, physical therapy sessions, therapeutic procedures, manual traction, special supplies, neuromuscular re-education, neuromuscular stimulator, myofasical release, joint mobilization misc. DME special supplies, and LSO, flex, surgical support rendered from 07-11-02 through 09-26-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for office visits, office visits with manipulation, physical therapy sessions, therapeutic procedures, manual traction, special supplies, neuromuscular re-education, neuromuscular stimulator, myofasical release, joint mobilization misc. DME special supplies, and LSO, flex, surgical support. 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 September 16, 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
09/13/02	E0745	$165.00	0.00	A	DOP	Rule134.600 (h)(13)	Per Rule 134.600 (h)(13) all tens units require pre authorization. Copy of approved pre-authorization was not submitted therefore,

							reimbursement is not recommended.
TOTAL		$165.00					The requestor is not entitled to reimbursement.

This Decision is hereby issued this 3rd day of February 2004.

Georgina Rodriguez
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 07-11-02 through 09-26-02 in this dispute.

This Order is hereby issued this 3rd day of February 2004.

David Martinez, Manager
Medical Dispute Resolution
Medical Review Division

January 29,2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-2906-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a 63 year-old male who sustained a work related injury on ___. The patient reported that while at work he was carrying a tire from the oil bay into the tire bay when he tripped over an air hose and fell forward hitting his head on a portable scale. The patient reported that he was knocked unconscious and when he awoke was bleeding from the head and was experiencing pain in his neck, left shoulder, right wrist, left wrist, right and left hand, low back and left knee. An initial evaluation that included X-Rays was on 4/3/02. The patient was initially treated with 12 weeks of preoperative therapy and underwent an EMG on 5/16/02. The patient also underwent an MRI of the right and left wrist on 5/15/02. The patient then underwent a left endoscopic carpal tunnel release on 6/21/02 followed by postoperative rehabilitation for the left upper extremity from 7/11/02 through 9/26/02.

Requested Services
Office visits, office visits with manipulations, physical therapy sessions,neuromuscular reeducation, manual traction, joint mobilization, myofascial release, therapeutic procedures,, misc. DME, special supplies, LSO, Flex, Surgical support and neuromuscular stimulator from 7/11/02 through 9/26/02.

Decision
The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision
The ___ chiropractor reviewer noted that this case concerns a 63 year-old male who sustained a work related injury to his neck, left shoulder, right wrist, left wrist, right and left hand, low back and left knee. The ___ chiropractor reviewer also noted that the patient was diagnosed with left carpal tunnel and underwent a left ecdoscopic carpal tunnel release on 6/12/02. The ___ chiropractor reviewer further noted that the patient was treated postoperatively with rehabilitation for the left upper extremity from 7/11/02 through 9/26/02. The ___ chiropractor reviewer explained that the treatment rendered from 7/11/02 through 9/26/02 was medically necessary and appropriated. Therefore, the ___ chiropractor consultant concluded that the office visits, office visits with manipulations, physical therapy sessions, neuromuscular reeducation, manual traction, joint mobilization, myofascial release, therapeutic procedures, misc. DME, special supplies, LSO, Flex, Surgical support and neuromuscular stimulator from 7/11/02 through 9/26/02 were medically necessary to treat this patient's condition.