MDR Tracking Number: M5-03-3109-01

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 01-28-03.

The IRO reviewed office visits, myofasical release, joint mobilization, manual traction, functional capacity evaluation (FCE), therapeutic procedures, NCV, somatosensory testing, senory nerve, F and reflex study rendered from 03-27-02 through 05-21-02 that were denied based upon “V”.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for office visits, myofasical release, joint mobilization, manual traction, functional capacity evaluation (FCE), therapeutic procedures, NCV, somatosensory testing, senory nerve, F and reflex study. 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 10-01-03, 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 Medical Review Division is unable to review this dispute for fee issues. Documentation was not submitted in accordance with Rule 133.307(l) to confirm services were rendered for dates of service 02-18-02, 07-25-02, and 07-30-02. Therefore reimbursement is not recommended.

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
02-18-02	97122	$35.00	0.00	No EOB	$35.00	133.307 (g)(3)	SOAP notes were not submitted for dates of service in dispute to confirm delivery of services. Therefore, no reimbursement recommended
	97750MT	$43.00	0.00		$43.00		
07-25-02	99213	$48.00	0.00		$48.00		
07-30-02	99213	$48.00	0.00		$48.00		
TOTAL		$174.00					The requestor is not entitled to reimbursement

This Decision is hereby issued this 20th day of January 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

September 29, 2003

Re: IRO Case # M5-03-3109-01

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, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. 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 his left wrist on ___ when a 50-pound bag fell on his wrist. He sought chiropractic treatment, and has received treatment in the form of traction, joint mobilization and myofascial release. He also has been evaluated with various studies including a motor nerve conduction study, a somatosensory study, and an "F" reflex study.

Requested Service(s)
Office visits / joint mobilization, myofascial release / traction / therapeutic procedure / somatosensory testing / NCV / F-reflex and FCE 3/27/02-5/21/02

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

Rationale
Based on the records provided for review, the patient apparently had an adequate trail of conservative treatment prior to the dates in dispute without relief of symptoms or improved function. A diagnosed sprain/strain should resolve with treatment within six weeks. Treatment for four months is unnecessary and unreasonable, and is an indication that treatment was ineffective. Referral of the patient for injections also indicates that treatment was not effective.
The documentation throughout the treatment period reviewed never changed; it was repetitive and lacking objective, quantifiable findings to support treatment. The documentation failed to show the necessity of the electrodiagnostc study conducted on 4/3/02, prior to an MRI. After the initial trial of therapy failed prior to the dates in dispute, the patient presented a condition for a hand specialist. The disputed treatment did not produce measurable or objective improvement.

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

Sincerely,