MDR Tracking Number: M5-03-3196-01

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, 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 August 7, 2003.

The IRO reviewed office visits, myofascial release, therapeutic exercises, ultrasound, physical medicine treatment, and DME rendered from 8/9/02 through 9/20/02 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. 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 September 12, 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
8/9/02	99213	$60.00	$0.00	F	$48.00	MFG, Evaluation/ Management Ground Rule (VI)(B)	Review of the Explanation of benefits, dated 11/11/02 reveals that the requestor was reimbursed for CPT code 99213 in the amount of $48.00, check #04863968. Therefore no further reimbursement is recommended.
TOTAL		$60.00	$0.00		$48.00		The requestor is not entitled to reimbursement.

This Decision is hereby issued this 29th day of January 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-03-3196-01

September 3, 2003

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, injections, surgery on 6/5/02 and 12 post-surgical rehabilitation treatments after left wrist injury on ___.

REQUESTED SERVICE(S)
Medical necessity of office visits, myofascial release, therapeutic procedure, ultrasound, physical medicine treatment and DME from 8/9/02 through 9/20/02.

DECISION
Uphold denial.

RATIONALE/BASIS FOR DECISION
Although it is reasonable to conclude that the initial 12 post-operative treatments were indicated, the medical records do not document the medical necessity for additional

post-surgical rehabilitation treatments. The physician did not examine the patient prior to beginning the treatments and on the physician's single encounter with the patient (occurring mid-way during the dates in question), his examination did not indicate any rationale or basis for the continued post-operative treatments. The medical records do not document that the treatments yielded any significant therapeutic gain beyond what would occur during the natural healing process. In fact, the patient's condition failed to respond to the treatments and required additional surgery.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.