MDR Tracking Number: M5-03-3206-01

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 8, 2003.

The IRO reviewed office visits and neuromuscular stimulator rendered from 8/13/02, 8/14/02 thru 8/29/02 denied based on "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Consequently, the requestor is not owed a refund of the paid IRO fee.

The office visits on 8/13/02 was found to be medically necessary.

The neuromuscular stimulators on 8/13/02 and all other office visits (99213) were not found to be medically necessary.

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 5, 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
8/26/02	97035	$26.00	$0.00	N	$22.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(iii) & (I)(A)(10)(b)	Review of the daily treatment log, dated 8/26/02 does not document one-to-one therapy and does not document time as required per the MFG. Reimbursement is not recommended for the ultrasound therapy.
	97014	$18.00	$0.00	N	$15.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii) & (I)(A)(10)(b)	Review of the daily treatment log, dated 8/26/02 meets the documentation requirements set forth by the MFG. Reimbursement is recommended in the amount of $15.00.
	97010	$15.00	$0.00	N	$11.00	MFG,	Review of the daily treatment

						Medicine Ground Rule (I)(A)(9)(a)(ii) & (I)(A)(10)(b)	log, dated 8/26/02 meets the documentation requirements set forth by the MFG. Reimbursement is recommended in the amount of $11.00.
8/28/02	97035	$26.00	$0.00	N	$22.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(iii) & (I)(A)(10)(b)	Review of the daily treatment log, dated 8/28/02 does not document one-to-one therapy and does not document time as required per the MFG. Reimbursement is not recommended for the ultrasound therapy.
	97014	$18.00	$0.00	N	$15.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii) & (I)(A)(10)(b)	Review of the daily treatment log, dated 8/28/02 meets the documentation requirement set forth by the MFG. Reimbursement is recommended in the amount of $15.00.
	97010	$15.00	$0.00	N	$11.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii) & (I)(A)(10)(b)	Review of the daily treatment log, dated 8/28/02 meets the documentation requirement set forth by the MFG. Reimbursement is recommended in the amount of $11.00.
8/29/02	97035	$26.00	$0.00	N	$22.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(iii) & (I)(A)(10)(b)	Review of the daily treatment log, dated 8/29/02 does not document one-to-one therapy and does not document time as required per the MFG. Reimbursement is not recommended for the ultrasound therapy.
	97014	$18.00	$0.00	N	$15.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii) & (I)(A)(10)(b)	Review of the daily treatment log, dated 8/29/02 meets the documentation requirements set forth by the MFG. Reimbursement is recommended in the amount of $15.00.
	97010	$15.00	$0.00	N	$11.00	MFG, Medicine Ground Rule (I)(A)(9)(a)(ii) & (I)(A)(10)(b)	Review of the daily treatment log, dated 8/29/02 meets the documentation requirements set forth by the MFG. Reimbursement is recommended in the amount of $11.00.
TOTAL		$177.00	$0.00		$144.00		The requestor is entitled to

							reimbursement in the amount of $78.00.

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 8/13/02 through 8/29/02 in this dispute.

This Order is hereby issued this 5th day of February 2004.

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

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-03-03206-01

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 injured left knee in the course of his duties as a ___ on ___.

REQUESTED SERVICE(S)
Neuromuscular stimulator on 8/13/02 and CPT code 99213 for the dates of 8/13/02, 8/14/02 through 8/29/02.

DECISION

Neuromuscular stimulator is denied. CPT code 99213 for the date 8/28/02 is approved. All other CPT codes of 99213 for the dates in question are denied.

RATIONALE/BASIS FOR DECISION

No documentation was supplied to support the medical necessity of the neuromuscular stimulator. CPT code 99213 is approved for the date of 8/28/02 since there is documentation that the physician evaluated the patient on that date. All other dates for CPT code 99213 are denied since no medical records were supplied to document that the physician evaluated the patient on those dates.

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.