

MDR Tracking Number: M5-04-0214-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 9-2-03.

The IRO reviewed hot/cold packs, ultrasound, electrical stimulation, therapeutic exercises, unlisted procedure, supplies/materials, and office visits from 5-30-03 through 7-24-03.

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.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 1-5-04, 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: The requestor submitted an updated table of disputed services on 2-12-04.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
4-9-03	97010 97035 97014 97110	\$28.00 \$27.00 \$22.00 \$ 7.00	\$0.00	C	\$11.00 \$22.00 ea 15 min \$15.00 \$35.00 ea 15 min	Rule 133.307(g)(3) (A-F)	Requestor did not challenge carrier's denial rationale. Neither party submitted a copy of the negotiated contract. No review can be made at this time.

7-17-03	99214	\$100.00	\$0.00	N	\$71.00	E/M GR IV C 2 and Rule 133.307(g)(3) (A-F)	This code requires two of these three key components - detailed history, detailed exam, and medical decision making of moderate complexity. The daily note does not meet this requirement. No reimbursement recommended.
8-19-03	99214	\$103.00	\$0.00	N	\$71.00		Relevant documentation was not submitted to support level of service; therefore, no reimbursement recommended.
TOTAL		\$287.00	\$0.00				The requestor is not entitled to reimbursement.

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

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

January 6, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter B**

RE: MDR Tracking #: M5-04-0214-01

___ 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 physician 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. This physician is board certified in physical medicine and rehabilitation.

The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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 ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 42 year-old female who sustained a work related injury on ____. The patient reported that while at work a box fell on her back. Diagnoses for this patient have included lumbar strain, right trapezius/arm strain and muscle strain, right shoulder pain and cervicalgia. The patient underwent an MRI of the right shoulder on 4/7/03 that showed minimal glenohumeral joint effusion, mild downsloping of the anterior acromion process and mild changes of supraspinatus tendinosis. An MRI of the cervical spine on 5/13/03 showed mild posterior annular bulging at C3-C4, C4-C5, C5-C6, and C6-C7 without significant acquired central spinal stenosis. Treatment for this patient has included physical therapy and oral medications.

Requested Services

Hot or cold packs, ultrasound electric stimulation, therapeutic exercises, ultrasound therapy, electrical stimulation, unlisted procedures and supplies/materials and office visits from 5/30/03 through 7/24/03.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a female patient who sustained a work related injury to his right shoulder on ____. The ___ physician reviewer indicated that the patient was noted to have pain in the neck/trapezius/right shoulder area, range of motion reported to be within normal limits and minimal limitation in the cervical spine with a right shoulder strength a 3/5. The ___ physician reviewer noted that the patient began physical therapy on 3/27/03 and by 4/1/03 right shoulder strength was 4+/5 and range of motion of the right shoulder and cervical spine were within normal limits. The ___ physician reviewer also noted that the patient continued to complain of pain and was receiving moist heat, ultrasound, stretching and electrical stimulation for treatment. The ___ physician reviewer explained treatment after 4/9/03 could have been provided at home with the use of a heating pad, home exercise program and pain management with medication. The ___ physician reviewer also explained that the patient had near normal strength and normal range of motion in the right shoulder and cervical spine. Therefore, the ___ physician consultant concluded that the hot or cold packs, ultrasound electric stimulation, therapeutic exercises, unlisted procedures and supplies/materials and office visits from 5/30/03 through 7/24/03 were not medically necessary to treat this patient's condition.

Sincerely,