

MDR Tracking Number: M5-04-0416-01

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 10-09-03.

The IRO reviewed office visits, unlisted neuromuscular procedure, functional capacity evaluation, work hardening, medical conference, pt care therapeutic procedures, and activities rendered from 05-21-03 through 07-28-03 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, unlisted neuromuscular procedure, functional capacity evaluation, work hardening, medical conference, pt care therapeutic procedures, and activities. 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 12-15-03, 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 following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
06-10-03	99213	\$48.00	0.00	No EOB	\$48.00	MFG, E & M GR(IV)(C)(2)	Soap notes support delivery of service. Recommended Reimbursement \$48.00
06-24-03	99213	\$48.00	0.00		\$48.00		Soap notes support delivery of service. Recommended Reimbursement \$48.00
06-30-03	99361	\$53.00	0.00		\$53.00	MFG E/M GR (XVIII)(B)	Soap notes support delivery of service. Recommended Reimbursement \$53.00

	97545W H (2 units)	\$128.00	0.00		\$64.00 per unit	MFG, MGR (II)(C) & (E)	Soap notes support delivery of service. Recommended Reimbursement \$128.00 (\$64.00 for 2 units)
	97546W H (6 units)	\$384.00	0.00		\$64.00 per unit	MFG, MGR (II)(C) & (E)	Soap notes support delivery of service. Recommended Reimbursement \$384.00 (\$64.00 for 6 units)
TOTAL		\$661.00					The requestor is entitled to reimbursement of \$ 661.00

This Decision is hereby issued this 5<sup>th</sup> day of April 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 05-21-03 through 07-28-03 in this dispute.

This Order is hereby issued this 5<sup>th</sup> day of April 2004.

David R. Martinez, Manager  
Medical Dispute Resolution  
Medical Review Division

December 12, 2003

**NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-04-0416-01**

\_\_\_ 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 23 year-old female who sustained a work related injury on \_\_\_\_. The patient reported that while at work she repetitive injury to her left wrist and elbow. The patient underwent an MRI of the left wrist and elbow on 3/24/03. On 4/11/03, the patient underwent an EMG/NCV. The diagnoses for this patient include median nerve neuritis, tenosynovitis of hand/wrist, radial nerve compromise and ulnar nerve compression/lesion. Treatment for this patient's condition has included physical therapy, injections, traction, myofascial release, and work hardening.

#### Requested Services

Office visits, unlisted neurological/neuromuscular dx proc., functional capacity evaluation, work hardening, med conference phys w/team coordin. Pt. Care; 30 min therapeutic procedures and activities from 5/21/03 through 7/28/03.

#### 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 23 year-old female who sustained a work related injury to her left wrist and elbow on \_\_\_\_. The \_\_\_ chiropractor reviewer also noted that the diagnoses for this patient included median nerve neuritis, tenosynovitis of hand/wrist, radial nerve compromise and ulnar nerve compression/lesion. The \_\_\_ chiropractor reviewer further noted that the treatment this patient's condition has included physical therapy, injections, traction, myofascial release, and work hardening. The \_\_\_ chiropractor reviewer explained that this patient did respond to treatment and has improved with the treatment rendered. Therefore, the \_\_\_ chiropractor consultant concluded that the office visits, unlisted neurological/neuromuscular dx proc., functional capacity evaluation, work hardening, med conference phys w/team coordin. Pt. Care; 30 min therapeutic procedures and activities from 5/21/03 through 7/28/03 were medically necessary to treat this patient's condition.

Sincerely,