

MDR Tracking Number: M5-04-0525-01

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 10-20-03.

The IRO reviewed office visits and therapeutic exercises rendered from 10-16-01 through 12-28-01 that were denied based upon "U".

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 and therapeutic exercises. 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.

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 01-13-04, 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:

DOS	CPT COD E	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
7-15-03	95851 (2 units)	\$72.00	0.00	F	\$36.00 per unit	MFG, MGR (I)(E)(4)	Report confirms delivery of service. Recommended Reimbursement \$72.00
7-29-03	99213	\$48.00	0.00	No EOB	\$48.00	MFG, E & M GR(IV)(C)(2)	Relevant information was not submitted in accordance with

	97110	\$210.00	0.00		\$35.00	MFG, MGR (I)(A)(9)(b)	133.307(g)(A-F) to support delivery of service for dates of service therefore reimbursement is not recommended.
	95851 (2 units)	\$72.00	0.00		\$36.00	MFG, MGR (I)(E)(4)	Report confirms delivery of service. Recommended Reimbursement \$72.00
TOTAL		\$402.00					The requestor is entitled to reimbursement of \$144.00

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 07-15-03 and 07-29-03 in this dispute.

This Decision is hereby issued this 26th day of April 2004.

Georgina Rodriguez
 Medical Dispute Resolution Officer
 Medical Review Division

January 7, 2004

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 IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification

statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This patient reported an injury to the left knee and ankle as a result of a work injury. The records indicate the patient slipped and fell on ice that had accumulated on a floor. She fell in a twisting motion, landing on the left leg. MRI was performed on February 12, 2003 and indicated some effusion along with meniscal degeneration and chondromalacia patella. She underwent extensive physical medicine and eventually had an arthroscopic surgical procedure to the knee on April 8, 2003. She underwent an evaluation by a designated doctor on March 5, 2003, which found her not to be at MMI.

DISPUTED SERVICES

Office visits and exercises were denied by the carrier as medically unnecessary

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The requestor fails to indicate the reasons that this extensive care went on for such an extended period of time. While it is reasonable to expect that some care will be rendered after an arthroscopic surgery to the knee, care in excess of 4 months post-surgical for this injury would require some justification for the care, which is not presented by the requestor. The documentation presented looks to be computer-based, which is certainly not an immediate negative to the documentation, but it fails to demonstrate why this very extensive program persisted for such a long period of time. Also, there is no justification of 5 units of exercise therapy each day on a knee/ankle injury. As a result, the reviewer has determined that the care rendered was not documented to be medically necessary.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,