

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-04-6476.M5

MDR Tracking Number: M5-04-0615-01

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 10-28-03.

The IRO reviewed electrical stimulation, office visits, therapeutic procedures, physical therapy, myofascial release, ultrasound therapy, tendon injections, osteopathic manipulations, unclassified drugs, hot or cold pack therapy, and special reports rendered from 11-20-02 through 06-16-03 that were 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 for electrical stimulation, office visits, therapeutic procedures, physical therapy, myofascial release, ultrasound therapy, tendon injections, osteopathic manipulations, unclassified drugs, hot or cold pack therapy, and special reports. 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 01-21-04, 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 CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
11-19-02	97750-FC	\$250.00	0.00	F		MFG MGR (I)(E)(2)(a)	Report submitted confirms delivery of service. Recommended Reimbursement \$200.00
06-16-03	97546-WH	\$32.00	0.00	F		MFG, MGR (II)(C) &	Relevant information was no submitted to support delivery of service.

						(E),	Reimbursement is not recommended	
TOTAL		\$282.00						The requestor is entitled to reimbursement of \$200.00

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 date of service 11-19-02 in this dispute.

This Decision is hereby issued this 11th day of May 2004.

Georgina Rodriguez
 Medical Dispute Resolution Officer
 Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION - AMENDED

Date: January 21, 2004

MDR Tracking #: M5-04-0615-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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 proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Physical Medicine and Rehabilitation/Pain Management reviewer (who is board certified in Physical Medicine and Rehabilitation/Pain Management) who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

This 52-year old female sustained a repetitive stress injury primarily to the right upper extremity while performing keyboard data entry work for _____. This became most problematic as of _____. She was initially treated conservatively.

She underwent upper extremity electrodiagnostic studies by _____ on 09/15/01 reportedly demonstrating right carpal tunnel syndrome, right cubital tunnel syndrome and cervical radiculopathy. The claimant also underwent a cervical MRI scan demonstrating a C4-5 disc herniation. On 01/23/02 a right carpal tunnel surgical decompression was performed by _____. Subsequently on 04/02/02 the claimant underwent anterior cervical discectomy/fusion by _____. Post-operatively the claimant remained symptomatic. On 09/19/02 and 11/19/02 the claimant presented for functional capacity evaluations. The 09/19/02 functional capacity evaluation was considered invalid because of poor patient effort. The subsequent 11/19/02 functional capacity evaluation could not be completed because of increased musculoskeletal pain the claimant was experiencing with activity. As of 01/06/03 the claimant was enrolled in a work hardening program however; she could not tolerate this because of symptomatic flaring and it was discontinued as of 02/05/03. The claimant was subsequently referred to the Chronic Pain Management Program. This program began as of 06/16/03.

Requested Service(s)

11/20/02 to 06/16/03 Electrical stimulation (unattended), office visits, medical procedures, therapeutic procedures, physical therapy, myofascial release, ultrasound therapy, tendon injections, osteopathic manipulation, unclassified drugs, hot/cold pack therapy, and special reports denied by the carrier as "V" unnecessary treatment with the peer review.

Decision

I agree with the insurance carrier that the above listed specific services requested are not medically necessary or reasonable with regard to management of the _____ work injury.

Rationale/Basis for Decision

The services listed from the time period of 11/20/02 through 6/16/03 are not medically necessary or reasonable because the claimant was unable to tolerate the 11/19/02 FCE. This should have indicated to the treating physicians that subsequent work hardening and other above "Requested Services" would not likely be restorative to the claimant with regard to the _____ work injury. During this time the claimant could continue with independent self treatment and an independent home exercise program.