

MDR Tracking Number: M5-04-0979-01

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 12-03-03.

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. The IRO reviewed unusual travel rendered from 07-22-03 through 07-25-03 that was denied based upon "U". Consequently, the requestor is not owed a refund of the 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 02-20-04, 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\$	Reference	Rationale
7-22-03 through 7-25-03 (3 DOS)	97799-CP-AP	\$3,500.00 (1 unit @ \$175.00 X 20 units) (DOS 7-22-03 billed 5 units, DOS 7-24-03 billed 7 units and DOS 7-25-03 billed 8 units)	\$0.00	A-DOS 7-22-03 Z – DOS 7-24-03 and 7-25-03	DOP	96 MFG MEDICINE GR (II)(G)(8)(9)	A, Z – Denied for preauthorization. Preauthorization was requested on 07-07-03 and obtained on 07-08-03 for 2 weeks of pain program. Requestor submitted relevant information to support DOP criteria. Reimbursement recommended in the amount of \$175.00 X 20 units = \$3,500.00
TOTAL		\$3,500.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$3,500.00

This Decision is hereby issued this 30th day of April 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

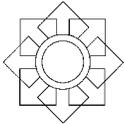
ORDER

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 07-22-03 through 07-25-03 in this dispute.

This Order is hereby issued this 30th day of April 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dlh

Enclosure: IRO Decision



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

February 17, 2004

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-04-0979-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in clinical psychology. TMF's health care professional 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 TMF 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 patient sustained an injury on ___ when she was pulling down an 8-10 pound object when the conveyor belt stopped and she was pulled forward. She reported cervical and left shoulder pain. She has attempted numerous conservative treatments and medications. She states she is having problems emotionally, with family, finances, and life functioning.

Requested Service(s)

Unusual travel from 07/22/03 through 07/25/03

Decision

It is determined that the unusual travel from 07/22/03 through 07/25/03 was not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The records provided established medical necessity for a chronic pain management program. However, there was no documentation relative to unusual travel requirements for this program. Therefore, it is determined that the unusual travel from 07/22/03 through 07/25/03 was not medically necessary.

Sincerely,



Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn