

MDR Tracking Number: M5-04-1062-01

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 12-11-03.

The IRO reviewed ultrasound therapy, paraffin bath and myofascial release rendered from 02-27-03 through 03-14-03 that was 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. 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 02-27-04, 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	MARS	Reference	Rationale
1-31-03 through 2-7-03 (4 DOS)	97018	\$100.00 (1 unit @ \$25.00 X 4 DOS)	\$0.00	F	\$16.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$16.00 X 4 DOS = \$64.00
1-31-03 through 2-7-03 (4 DOS)	97035	\$104.00 (1 unit @ \$26.00 X 4 DOS)	\$0.00	F	\$22.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$22.00 X 4 DOS = \$88.00
2-6-03	99212	\$35.00 (1 unit)	\$0.00	F	\$32.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service.

							Reimbursement recommended in the amount of \$32.00
TOTAL		\$239.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$184.00

**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 01-31-03 through 02-07-03 in this dispute.

This Findings and Decision and Order are hereby issued this 4<sup>th</sup> day of May 2004.

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

February 24, 2004  
**Amended February 26, 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**

\_\_\_ suffers from a very old accumulative trauma that occurred on \_\_\_. The oldest documentation provided to the reviewer is from \_\_\_ and dated 9/21/00. The history doesn’t discuss the original mechanism of injury, but it is stated that the activities of her work caused her symptomatology.

She is a bilingual operator and most of her work is on the computer. By this time, she has already had bilateral carpal tunnel release, right cubital tunnel releases and two left cubital tunnel releases. Most of her pain this time is over the left cubital tunnel. She eventually had a tunnel of Guyon release on 3/19/03.

#### DISPUTED SERVICES

Under dispute is the medical necessity of ultrasound, paraffin bath and myofascial release from 2/27/03 through 3/14/03 regarding this patient.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

This dispute encompasses five visits, consisting of office visits, myofascial release, paraffin and ultrasound. There is only one clinical note from the treating doctor for the date of 3/6/03. \_\_\_ speaks of the patient recently having an injection for a trigger thumb on the left and is planning to go ahead with the tunnel Guyon release on the left hand. Current pain levels for these dates range from 2 to 5, with respect to thumb. There is no documentation substantiating the medical necessity of ongoing passive care or the efficacy of prior care with regards to these dates of service.

\_\_\_ 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,