

MDR Tracking Number: M5-04-2522-01

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. The dispute was received on 3-30-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits and unlisted physical medicine and rehabilitation service/procedure rendered from 5/15/03 through 6/09/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 5/15/03 through 6/09/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 17th day of June 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

May 25, 2004

IRO Certificate # 5259
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An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

Patient is a 39-year-old male laborer who was pushing a dolly when he was struck by a truck and knocked to the ground on ___, injuring his right knee and shoulder. Eventual MRI's of both reveal possible rotator cuff tear in the shoulder, and findings commensurate with bruising of the knee. Some time in the summer, he was seen by a TWCC designated doctor who found the patient to be at MMI with 0% impairment. Treatment continued and eventually, a chronic pain management program was initiated. In May of 2003, the patient was still off work.

REQUESTED SERVICE (S)

Office visits (99215) and unlisted physical medicine & rehab service or procedure (97799-CP) for dates of service 05/15/03 through 06/09/03.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Neither the diagnosis submitted nor the medical records reviewed support the medical necessity of such a high level Evaluation and Management (E/M) service to reevaluate this patient. Further, according to the carrier's peer review doctor, it was the opinion of the designated doctor nearly a year prior to these services being provided that the patient was at MMI and without impairment. Therefore, it would appear that these treatments were excessive, not supported by objective findings, and failed to cure or relieve the effects naturally resulting from the compensable injury, promote recovery, or enhance the ability of the employee to return to or retain employment (Texas Labor Code 408.021). As such, these services did not meet the criteria for what is deemed medically necessary.