

MDR Tracking Number: M5-05-1757-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 2-22-05.

The IRO reviewed office visit on 5-6-04 and FCE on 4-23-04.

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 paid IRO fee.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 3-22-05, 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.

Code 99213 billed for date of service 4-14-04 was denied as global. Per correspondence dated 4-18-05 from the requestor, the carrier paid this bill. Therefore, no dispute exists.

The above Findings and Decision is hereby issued this 18th day of April 2005.

Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO Decision

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

|  |                      |
|--|----------------------|
| TWCC Case Number:                                      |                      |
| MDR Tracking Number:                                   | M5-05-1757-01        |
| Name of Patient:                                       |                      |
| Name of URA/Payer:                                     | Atlantis Healthcare  |
| Name of Provider:<br>(ER, Hospital, or Other Facility) | Atlantis Healthcare  |
| Name of Physician:<br>(Treating or Requesting)         | Marivel C. Subia, DC |

April 12, 2005

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 Texas Medical Foundation, 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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: Texas Workers Compensation Commission

#### CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Correspondence, examination and treatment records from the provider.
2. Carrier review
3. Carrier attorney correspondence
4. Designated doctor examination and impairment rating
5. MRI report
6. EOBs
7. FCE

The claimant underwent physical medicine treatments after injuring his left ankle when he twisted it on a net at work on \_\_\_\_ while at work. After surgical repair of the anterior talofibular ligament on 11/06/03, the claimant switched treating doctors and was first seen by the provider on 03/11/04 who performed an FCE and ordered an MRI.

#### REQUESTED SERVICE(S)

CPT code 99213 office/outpatient visit on 05/06/04 and 97750-FC Functional Capacity Evaluation on 04/23/04.

#### DECISION

Denied.

#### RATIONALE/BASIS FOR DECISION

No treatment records were available for review during the time period immediately preceding or following the treatment in question. Therefore, it is unknown what kinds of therapies and/or treatments were attempted; what was beneficial and

what was not; or even what treatment was attempted based on the FCE that was performed. Without medical treatment records that answer those questions, there is less than sufficient documentation to support the medical necessity of the disputed treatment.

More importantly, the designated doctor – who carries presumptive weight and after physical examination – opined on 04/05/04 that the claimant was MMI; that “the clinical condition is not likely to improve with further active medical treatment and/or surgical intervention;” and “employability is not likely to improve with further active medical treatment and/or surgical intervention.” Therefore, there was no basis whatsoever to perform an FCE a mere 18 days after the designated doctor examination or the office visit on 05/06/04.

And finally, it should be noted that the 05/03/04 MRI reported an impression of a chronic tear of the anterior talofibular ligament. Nevertheless, the patient’s condition (absent any documentation of re-injury between 04/05/04 and 05/03/004) was determined by the designated doctor with that possible condition present.