

MDR Tracking M5-05-1981-01

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 3-16-05.

In accordance with Rule 133.308 (e)(1) the following date(s) of service are not timely and are not eligible for this review: 3-1-04 through 3-5-04.

The IRO reviewed the electrical stimulation, ultrasound, manual therapy technique, therapeutic exercises, durable medical equipment and neuromuscular re-education from 3-30-04 through 5-10-04 that were denied by the insurance carrier for medical necessity.

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 electrical stimulation, ultrasound, manual therapy technique, therapeutic exercises, durable medical equipment and neuromuscular re-education from 3-30-04 through 5-10-04 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved.

On 4-27-05 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.

Regarding CPT Code 97032 and 3-31-04 and 4-2-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$40.08 (\$20.04 X 2 DOS).**

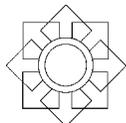
Regarding CPT code 97140 on 4-2-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$33.91.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling 73.99 from 3-31-04 through 4-2-04 outlined above as follows: In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Decision and Order is hereby issued this 16th day of June, 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

June 8, 2005

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 #: M5-05-1981-01
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 Chiropractic Medicine. 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 48 year-old female injured her right wrist and elbow on ____ after doing repetitive work for the past 12 years. She had bilateral carpal tunnel surgery 6 to 7 years ago, after recovery, she returned to the same repetitive work. She now works in inventory that requires repetitive writing. She has been treated with therapy, medications and surgery.

Requested Service(s)

Electrical stimulation, ultrasound, manual therapy technique, therapeutic exercise, durable medical equipment, neuromuscular re-education for dates of service 03/30/04 through 05/10/04

Decision

It is determined that there is no medical necessity for the electrical stimulation, ultrasound, manual therapy technique, therapeutic exercise, durable medical equipment, and neuromuscular re-education for dates of service 03/30/04 through 05/10/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. In this case, the patient reported a pain scale rating of 7 out of 10 in March 2004 and an 8 out of 10 in May 2004. There is no objective or functional improvement in the patient's pain relief or condition, no promotion of recovery, no enhancement of the employee's ability to return to employment and no evidence of a change of treatment plan to justify additional treatment in the absence of a positive response. Therefore, the electrical stimulation, ultrasound, manual therapy technique, therapeutic exercise, durable medical equipment, and neuromuscular re-education for dates of service 03/30/04 through 05/10/04 is not medically necessary to treat this patient's medical condition.

Sincerely,



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

GBS:dm

Attachment

Attachment

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M5-05-1981-01

Information Submitted by Requestor:

- Requestor's Position
- Progress Notes
- Procedures
- Diagnostic Tests

Information Submitted by Respondent:

- Progress Notes
- Maximum Medical Impairment
- Peer Review
- Independent Medical Review
- Procedures
- Diagnostic Tests
- Claims/Miscellaneous