

MDR Tracking Number: M5-02-2100-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

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 the only issue to be resolved. The therapeutic procedures as well as the office visits, for dates of service December 14, 17, and 19th, were found to be medically necessary. The therapeutic massages, sterile whirlpool, and spray and stretch services were found to be not medically necessary. The respondent raised no other reasons for denying reimbursement.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
12/14/01 12/17/01 12/19/01	97124 (2) 97124 (2) 97124 (2)	\$56.00 \$56.00 \$56.00	0.00 0.00 0.00	U U U	\$28.00/unit x 6 = \$168.00	IRO decision	The IRO determined therapeutic massages were not medically necessary and therefore not reimbursable.
12/14/01 12/17/01 12/19/01	97022-22 97022-22 97022-22	\$40.00 \$40.00 \$40.00	0.00 0.00 0.00	U U U	\$20.00/unit x 3 = \$60.00	IRO decision	The IRO determined sterile whirlpool was not medically necessary and therefore not reimbursable.
12/17/01 12/19/01	97139-SS 97139-SS	\$35.00 \$35.00	\$0.00 \$0.00	U U	DOP	IRO decision	The IRO determined spray and stretch was not medically necessary and therefore not reimbursable.
12/14/01 12/17/01 12/19/01	97110 97110 97110	\$140.00 \$140.00 \$140.00	\$0.00 \$0.00 \$0.00	U U U	\$35.00/unit x 12 = \$420.00	§133.1(a)(8)	The IRO determined the therapeutic procedures were medically necessary. The carrier did not object to fair and

							reasonable reimbursement, therefore, reimbursement is recommended as billed, \$420.00.
12/14/01	97211	\$18.00	\$0.00	U	\$18.00/visit x 3 = \$54.00	§133.1(a)(8)	The IRO determined the office visits were medically necessary. The carrier did not object to fair and reasonable reimbursement, therefore, reimbursement is recommended as billed, \$54.00.
12/17/01	97211	\$18.00	\$0.00	U			
12/19/01	97211	\$18.00	\$0.00	U			
TOTAL		\$832.00					The requestor is entitled to reimbursement of \$474.00.

Consequently, the commission has determined that the requestor prevailed on the majority of the medical fees (\$474.00). Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to refund the requestor **\$470.00** for the paid IRO fee.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay \$944.00 plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 12/14/01 through 12/19/01 in this dispute.

This Order is hereby issued this 23rd day of, May 2002.

Marguerite Foster
 Medical Dispute Resolution Officer
 Medical Review Division

MF/mf

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

May 9, 2002

Re: Medical Dispute Resolution
MDR #: M5-02-2100-01
IRO Certificate No.: 5055

Dear:

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). Texas Workers' Compensation Commission Rule 133.308 "Medical Dispute Resolution by an Independent Review Organization", effective January 1, 2002, allows an injured employee, a health care provider and an insurance carrier to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Orthopedic Surgery.

THE PHYSICIAN REVIEWER OF THIS CASE PARTIALLY AGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **5 (five)** days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P. O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U. S. Postal Service from the office of the IRO on this 9th day of April, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is ___ for ___. I have reviewed the medical information forwarded to me concerning TWCC Case #M5-02-2100-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Four-page SOAP note for 12/14/01.
2. Five-page peer review by ___, dated 12/16/01.
3. Exercise progress sheet, dated 12/17/01.
4. Four-page SOAP note for 12/17/01.
5. Four-page SOAP note for 12/19/01.
6. Ten-page request for reconsideration, dated 1/24/02.
7. Two-page violation request to compliance and practices.
8. Six-page case summary from _____, dated 4/11/02.
9. Six pages of EOB's for dates of service 12/14/01, 12/17/01, and 12/19/01.
10. Two-page letter from ___ to ___, dated 4/08/02.
11. Three-page table of disputed services.
12. Two pages from ___, appealing the peer review.
13. One-page request for IRO from TWCC, dated 4/02/02.

B. SUMMARY OF EVENTS:

The patient sustained an injury on ____, when a teacher opened a door and crushed the patient's left hand between the cart handle and the door handle. The patient was examined by ____ on Monday, 11/12/01. ____ prescribed treatment daily for two weeks and then three times weekly for six weeks. The patient was taken off work and kept off work until 1/07/02.

The patient had two FCE's, one on 11/27/01, two weeks after her injury, which showed restrictions in some areas, and a second on 1/07/02, which returned her to work. The patient had an MRI of her right wrist; the actual report was not included in the review material, but ____ documentation only mentions CTS findings.

C. OPINION:

I PARTIALLY AGREE/DISAGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

Based upon the documentation submitted, the therapeutic massages performed on the 14th, 17th, and 19th of December 2001, were not medically necessary because the patient was rating her pain at 0 out of 10, 1 out of 10, and 0 out of 10, respectively. The sterile whirlpool was not medically necessary at this point as well for the same reasons. Additionally, the application of moist heat to the injured hand in order to stimulate superficial circulation could just have effectively been applied through a paraffin bath, hydroculation pads, or a non-sterile whirlpool, as this patient has no history of skin abrasions or immuno-compromising conditions. Since there is an office visit charge for each of these days, the continued integrity of the patient's integument could easily be verified by the attending physician. The spray and stretch services were not medically necessary on the 17th and 19th of December 2001. The pain levels were too low, and the patient's documented ability to exercise and grip the exercise bar repeatedly for nearly an hour belies the need for this procedure.

I do believe the exercises administered during the timeframe named above (December 14, 17, and 19th) were medically necessary to strengthen the contused connective tissue of the patient's wrist and hand. I am also agreeing with the office visit charges for the 14th, 17th, and 19th.

The clinical basis and screening criteria that were utilized in interpreting the involved medical records and subsequent rendering of the above determinations are derived from professional clinical observations, experience, and interaction with other healthcare providers over the 12 years that I have been actively practicing in the Physical Medicine and Rehabilitation field.

D. ADDITIONAL COMMENTS:

None.

E. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 7 May 2002