MDR Tracking Number: M5-02-3129-01

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 and determined, the total amount recommended for reimbursement ($757.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the **requestor did not prevail** in the IRO decision. Consequently, the requestor is not owed a refund of the paid 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 the only issue to be resolved. The office visits, joint mobilization, myofascial release, two units of therapeutic activities for both 2/20/02 and 3/11/02 and FCE completed on 4/29/02 were found to be medically necessary. The remaining dates of service, 8/14/01 through 2/11/02, and 5/6/02 through 7/4/02 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement charges for the office visits, joint mobilization, myofascial release, two units of therapeutic activities for both 2/20/02 and 3/11/02 and FCE completed on 4/29/02.

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 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 Order is applicable to dates of service 8/14/01 through 7/4/02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 7th day of March 2003

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

December 17, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5 02 3129 01
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.

This case was reviewed by a licensed Doctor of Chiropractic. 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

___, a 33-year-old male, sustained an on the job injury to his right upper extremity while working as a metal cutter, working construction for ___ on ___. Mechanism of injury consisted of catching his right index finger in the chains of a machine, pulling up on his right upper extremity, wrenching his wrist. He consulted that same day with ___ for ___. He was referred to an orthopedist, ___, with exam showing laceration to the right index finger, diffuse dorsal pain across the wrist with reduced to flexion/extension. X-rays were taken and revealed a minimally separated well aligned post fracture to the index finger, along with prior changes consistent with Keinbock's avascular necrosis/lunate disease, along with old scaphoid nonunion, injury to the capitate and a smooth old ulna styloid avulsion. Impression was that the patient has sustained a crush injury to the index finger with a mild laceration and distal phalanx fracture, with wrist sprain superimposed upon prior Keinbock's disease with arthritic changes of the carpus.

MRI was recommended, and he was placed on light duty, with a wrist splint and medication. Diagnosis was updated to include a scaphoid fracture on 6/21/01. The MRI performed on 7/12/01 confirmed advanced Keinbock's lunate and accompanying moderate degenerative changes of the carpals. The patient had continuing pain and

discomfort which started to interfere with sleeping daytime activity by 7/19/01. ___ suggested a proximal row carpectomy/fusion to relieve arthritis that had been aggravated directly by the work injury. The patient then changed treating doctors on 8/10/01 to ___ and was subsequently treated by him and his associates. Minimal exam findings are noted, consisting of edema of the right wrist, limited range motion and pain, along with "positive" Tinel's, Bunnel's, Allen's, Phalen's and Finkelstein's special testing. There was also reduced finger flexion strength noted on the right along with a reduced sensory appreciation of C7 also the right. Treatment progressed with ultrasound, myofascial release, traction, joint mobilization and neuromuscular reeducation, three times a week. Patient was also taken off work. He was prescribed paraffin wax bath, biofreeze topical agent and a cryo unit. The patient's complaints seem to consistently be of right hand pain with radiation from the wrist to the 3rd and 4th fingers, with increased pain on lying down. Pain scale was given as 8/10. Follow-up x-rays on 8/23/01 confirmed old injuries to the right wrist.

The patient was then referred for second opinion purposes to a hand surgeon, ___ on 8/29/01. He assessed that the fracture of the distal phalanx of his right index finger had healed. He also assessed a long-standing problem at the right wrist, difficult to relate to his current injury, although possible that the patient was tolerating a degree of lunate deterioration which was then aggravated by a new injury. According to the patient the therapy had been aggravating the wrist and adding to the swelling. His impression was that he should not be doing any kind of exercise with the wrist, He recommended that the inflammation should be allowed to settle down and that he would require most likely a surgery. Treatment with ___ continued on unabated, with the same treatment regime despite this report. Re-exam findings on 9/6/01 appeared to be identical to the initial exam of 8/10/01. Electrodiagnostic studies were performed on 9/24/01, EMG revealed evidence of chronic medial nerve neuropathy at the wrist, confirmed by NCV with slowing of the median motor and sensory distal latencies. Re-exam on 10/4/01 again showed no obvious change from the initial presentation, treatment continued. He was referred to ___. who noted that continued therapy, three times per week, had failed to provide any improvement per the patient. ___ impression was of severe wrist pain probably related to Kienbock's disease, aggravated from his injury, with a carpal tunnel syndrome. Recommendation was proximal row corpectomies / total wrist fusion along with open carpal tunnel release as a result of nonresponse to conservative treatment. Again, treatments continued in the same fashion with ___. Yet another consultation was obtained from ___, on 11/1/01. He concurred with previous opinions that the injury aggravated Kienbock's disease and concurred with the requirements for surgery including carpal tunnel release. A right total wrist arthrodesis with iliac crest bone graft and synthesis wrist plate was performed by ___ on 11/26/01.

Follow-up 12/10/01 revealed appropriate healing with moderate edema at the wrist, limited range motion fingers. Referral was made back to ___ for finger range of motion exercise and edema control. Follow-up treatment notes through December revealed significant tenderness, swelling and range motion limitations. Joint mobilization and cold packs were applied initially with progression to myofascial release, manual traction, stretching and hand dexterity exercises five times per week for four weeks. The patient

was prescribed a wrist Thermostim glove on 1/9/02. Follow-up x-rays on 1/10/02 revealed fusion of multiple carpal bones and radiocarpal joint without signs of periosteal reaction or infection. Re-examination on 01/11/02 reported that range motion is limited but with non quantified improvement Treatment continued multiple times per week. Patient was seen for follow-up with ___ on 2/4/02. Assessment was slow improvement in pain relief but no evidence of any complications or problems. Recommendation was continued therapy with ___ three times per week for four weeks including hot wax baths to loosen up the joints and improve range of motion and ultrasound as necessary with aggressive finger flexion exercises. The patient was then seen for RME purposes by ___ on 2/05/02. The patient determined not to be at MMI, however he believed that the patient could perform a home exercise program, elevation of the hand and graduated wrist strengthening without formal physical therapy. He anticipated a return to limited physical activities by the beginning of April 2002.

Re-examination on 2/12/02 indicated range motion of the fingers had improved significantly, pain scale was related as a 6/10 with less pain overall. Again no verifiable objective range motion comparisons were available. The patient then progressed to a work hardening environment, in conjunction with continuation of therapy. Outcomes assessment evaluations were attempted to between 3/29/02 and 4/5/02. This showed no improvement. The patient followed up with ___ on 4/17/02 at which time it was noted that his therapy consists of giving him sheets of paper with instructions for exercises which he does, but without one-on-one stretching or even warming of the hand. Recommendation for further care with one-on-one stretching of the fingers as well as a warming protocol would improve range of motion.

A functional capacity evaluation was performed on 4/29/02 by ___. The evaluation placed him in a medium to heavy physical demand level with continuation of work hardening recommended. On 5/15/02 ___ assessment reveal that the patient is still having some pain and tenderness to his scar but no pain with motion and had good range motion fingers. He had some diminished strength. ___ felt was nothing more that he could do for the patient. Patient continued with therapy, and remained off work. Referral for pain management program was requested and a psychological evaluation was performed on 6/4/02. Axis I diagnosis was atypical depression with pain disorders associated with psychological and general medical condition. The patient was then referred to ___ on 9/30/02 for impairment rating purposes. He did not believe that the patient was at MMI as he had not yet completed some pain management.

DISPUTED SERVICES

The carrier denies the medical necessity of office visits, physical medicine, myofascial release, joint mobilization, data analysis, ultrasound, manipulations, therapeutic activities, special reports and radiography.

DECISION

The reviewer agrees with the prior adverse determination, except for the dates of February 20, 2002 and March 11, 2002. For those dates, he finds some of the treatment was necessary. Also, the reviewer finds the FCE performed on April 29, 2002 to be necessary.

BASIS FOR THE DECISION

I do not find establishment of medical necessity for the disputed care provided on 8/22/01, 9/4/01, 9/18/01, or 10/4/01. The patient failed to respond to initial conservative care as evidenced by three subsequent reevaluation's and the opinions of at least three separate independent referral physicians, who all stated unequivocally that the patient was a surgical candidate. Given the patient's obvious lack of response to care, there is no indication that continued ongoing care four months after the initiation of conservative treatment is medically necessary. Similarly, a six to eight week postoperative course of stretching and strengthening is deemed to have been sufficient to sustain flexibility

Medical necessity he can be established for services on 2/20/02 and 3/11/02, although the application of the number of therapies is excessive. Considering the limited extent of the injury, it would seem reasonable to allow only the following: one E&M 99213 level service, one unit of joint mobilization, one unit of myofascial release, and two units of therapeutic activities for both 2/20/02 and 3/11/02 dates of service.

2/5/02: 99244 E&M code level 4: The only documentation I have for this date of service is a RME performed by ___ at the request of the carrier. There is no supporting documentation from the provider for this date of service.

2/11/03, 5/06/02, 5/20/02 & 5/30/02: 99090 code is described as in the CPT code book as analysis of data / information stored in a computer such as ECG, BP, hematologic data etc. I fail to see the relevance or medical necessity for this code as it pertains to review of an x-ray or FCE report.

The functional capacity evaluation of 04/29/02 is considered to be medically necessary.

By 5/15/02, the patient was evaluated with still having some pain and tenderness to his scar but no pain with motion and good range motion of the fingers. He had some diminished strength. ___ felt was nothing more that he could do for the patient.

There is no justification for ongoing continued extensive physical therapy beyond this 05/15/02 and it is not defended by either subjective or objective means in the documentation provided.

___ 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,