

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER: 453-04-6622.M5

MDR Tracking Number: M5-04-0488-01

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 10-16-03.

The IRO reviewed office visits and therapeutic exercises rendered from 10-16-01 through 12-28-01 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for office visits and therapeutic exercises. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

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 not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-31-03, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
06-05-03	95851	\$36.00	0.00	G	\$36.00	MFG, MGR (I)(E)(4)	Range of motion (95851) is not global to any other service billed on this date Recommended Reimbursement \$36.00
06-19-03	95851	\$36.00	0.00	G	\$36.00	MFG, MGR (I)(E)(4)	Range of motion (95851) is not global to any other service billed on this date Recommended Reimbursement \$36.00
07-02-03	97750 MT	\$43.00	0.00	G	\$43.00	MFG MGR (I)(E)(3)	Muscle testing is not global to any other service billed on this date. Recommended Reimbursement \$43.00

TOTAL	\$115.00	The requestor is entitled to reimbursement of <b>\$115.00</b>
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This Decision is hereby issued this 17<sup>th</sup> day of May 2004.

Georgina Rodriguez  
 Medical Dispute Resolution Officer  
 Medical Review Division

**ORDER.**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 Decision is applicable for dates of service 05-29-03 through 07-14-03 in this dispute.

This Order is hereby issued this 17<sup>th</sup> day of May 2004.

Roy Lewis, Supervisor  
 Medical Dispute Resolution  
 Medical Review Division

**NOTICE OF INDEPENDENT REVIEW DECISION**

December 23, 2003

MDR Tracking #: M5-04-0488-01  
 IRO Certificate #: IRO 4326

The \_\_\_ 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 \_\_\_ 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 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 care. \_\_\_ 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 \_\_\_ 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 patient sustained a repetitive injury to her left wrist, reported on \_\_\_\_. Diagnostic studies were consistent with carpal tunnel syndrome and she had a release performed on 03/11/03. She saw a chiropractor for treatment and therapy pre and post operatively.

Requested Service(s)

Office visits/outpatient visits, therapeutic exercises, and subsequent visit from 05/29/03 through 07/14/03

Decision

It is determined that the office visits/outpatient visits, therapeutic exercises, and subsequent visit from 05/29/03 through 07/14/03 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient had a number of injuries to the left wrist that lacked sufficient documentation of efficient medical management, which became a factor in the chronicity of her injury. Diagnostic imaging on 11/22/02 showed evidence on the presence of carpal tunnel syndrome (CTS) and tear of triangular fibrocartilage. The use of invasive applications to correct the pathology noted in the patient should have been the first indication of the need for continued clinically supervised rehabilitation from 05/29/03 through 07/14/03. Given the nature of chronic pain behavior exhibited by this patient, it would not be feasible to just release her to a home rehabilitation program for post surgical rehabilitation efforts. Patients that display chronic pain behaviors need a greater degree of goal oriented structure that can only be provided in a clinically supervised environment.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- Case-Smith J. Outcomes in hand rehabilitation using occupational therapy services. Am J Occup Ther. 2003 Sep-Oct;57(5):499-506.
- *Clinical practice guidelines for chronic, non-malignant pain syndrome patients II: An evidence-based approach.* J Back Musculoskeletal Rehabil 1999 Jan 1; 13; 47-58.
- Roberts-Yates C. *The concerns and issues of injured workers in relation to claims/injury management and rehabilitation: the need for new operational frameworks.* Disabil Rehabil. 2003 Aug 19;25(16):898-907.

Sincerely,