

MDR Tracking Number: M5-04-0555-01

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 10-28-03. In accordance with Rule 133.307(d)(1) A dispute on a carrier shall be considered timely if it is filed with the division no later than one year after the dates of service in dispute therefore dates of service 10-21-02 and 10-22-02 in dispute are considered untimely and will not be addressed in this review.

The IRO reviewed therapeutic activities, therapeutic procedures, unlisted physical medicine/rehab, aquatic therapy rendered from 10-23-02 through 11-20-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for unlisted physical medicine/rehab.

The Medical Review Division has also determined that the **requestor prevailed** on the issues of medical necessity for therapeutic activities, therapeutic procedures, aquatic therapy. Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees (\$2270.00). 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 \$650.00** 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 03-16-04, 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	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
12/06/02	97750-FC	\$200.00	0.00	No EOB	\$100.00 per hour	MFG MGR (I)(E)(2)(a)	Relevant information was not submitted to confirm delivery of service. Reimbursement is not recommended
TOTAL		\$200.00					The requestor is not entitled to reimbursement.

This Decision is hereby issued this 29th day of April 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 10-23-02 through 11-20-02 in this dispute.

This Order is hereby issued this 29th day of April 2004.

Roy Lewis, Supervisor
 Medical Dispute Resolution
 Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

March 12, 2004

Re: IRO Case # M5-04-0555

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation

Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is board Certified in Physical medicine and Rehabilitation, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient was injured on ___ when her right hand got caught in a machine and she suffered a pulling and crushing type injury to her wrist and hand. Emergency room x-rays were negative for fracture. A 2/26/02 MRI of the right wrist and forearm were negative for any abnormalities. EMG/NCS on 4/18/02 were normal, without evidence of entrapment syndrome or radiculopathy in the upper extremities. The patient was evaluated by a hand surgeon on 3/35/02, and he injected the radial carpal tunnel joint and recommended continued use of a splint. The patient also continued with therapy with her treating D.C. The patient, however, continued with pain despite non operative treatment. On 7/19/02 surgery was performed that consisted of a right open carpal tunnel release, right pronator release of the forearm, and right wrist arthroscopy with synovial debridement. The patient started post operative therapy in late August 2002. Therapy continued until late November 2002.

Requested Service(s)

Therapeutic activities, direct pt, therapeutic procedures, unlisted physical meds, rehab; therapeutic activities, aquatic therapy 10/23/02-11/20/02

Decision

I disagree with the carrier's decision to deny the requested services, except for CPT code 97799-MR, unlisted physical medicine and rehab service.

I agree with the denial of code 97799-MR.

Rationale

Post surgical rehabilitation began one month after surgery and lasted for 12 weeks.

Physical therapy notes during that time document slow but steady progress in the patient's range of motion, strength and pain. In follow-up in 10/30/02 the patient's surgeon noted progress in range of motion, but also noted that range of motion was limited with stiffness. The surgeon recommended continued therapy three times per week for four more weeks. The surgeon was also concerned about early formation of complex regional pain syndrome. Therapy would be required to help prevent development of this very difficult problem.

No documentation was provided in the records provided for review explaining the need for a separate code and separate charge, apart from the other services listed and documented.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.