

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER: 453-04-8259.M5

MDR Tracking Number: M5-04-0674-01

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 11-03-03. Date of service 11-11-03 codes 97750-MT and date of service 11-13-02 codes 99213 were withdrawn on 01-26-04 by \_\_\_ at \_\_\_.

The IRO reviewed massage therapy, electrical stimulation-unattended, diathermy, office visits, myofascial release, joint mobilization, therapeutic exercises, therapeutic procedures, physical performance tests, office visit-evaluation, ROM measurements and supplies-materials rendered from 12-06-02 through 04-07-03 that were denied based upon “V”.

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.

<b>DOS</b>	<b>CPT CODE</b>	<b>Billed</b>	<b>Paid</b>	<b>EOB Denial Code</b>	<b>MAR\$</b>	<b>Reference</b>	<b>Rationale</b>
01-28-02	97124	\$20.00 (1 unit)	\$0.00	V	\$28.00	IRO DECISION	IRO determined service was medically necessary. Recommend reimbursement in the amount of \$20.00
01-27-02	97014	\$17.00 (1 unit)	\$0.00	V	\$15.00	IRO DECISION	IRO determined service was medically necessary. Recommend reimbursement in the amount of \$15.00
02-10-03	97014	\$17.00 (1 unit)	\$0.00	V	\$15.00	IRO DECISION	Medical necessity was not established. No reimbursement recommended.
01-27-03 01-28-03 (2 DOS)	97024	\$50.00 (1 unit @ \$25.00 X 2 DOS)	\$0.00	V	\$21.00	IRO DECISION	IRO determined services were medically necessary. Recommend reimbursement in the amount of \$21.00 X 2 DOS = \$42.00
12-19-02	99214-52	\$37.50 (1 unit)	\$0.00	V	\$71.00	IRO DECISION	IRO determined service was medically necessary. Recommend reimbursement in the amount of \$37.50
12-17-02	99214-52	\$37.50 (1 unit)	\$0.00	V	\$71.00	IRO DECISION	IRO determined service was not medically necessary. No

							reimbursement recommended.
04-01-03	99215-52	\$62.50 (1 unit)	\$0.00	V	\$103.00	IRO DECISION	IRO determined service was not medically necessary. No reimbursement recommended.
02-11-03	99215	\$125.00 (1 unit)	\$0.00	V	\$103.00	IRO DECISION	IRO determined service was not medically necessary. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
12-06-02 12-09-02 12-11-02 (3 DOS)	99213	\$150.00 (1 unit @ \$50.00 X 3 DOS)	\$0.00	V	\$48.00	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
01-21-03 02-03-03	99213-52	\$50.00 (1 unit @ \$25.00 X 2 DOS)	\$50.00	N/A	\$48.00	Rule 133.307 (g)(3)(A-F)	Per explanation of benefits from respondent payment in full made. Check reference #05131387 for DOS 01-21-03 and check reference 05260109 for DOS 02-03-03
12-12-02 through 04-07-03 (22 DOS)	99213-52	\$550.00 (1 unit @ \$25.00 X 22 DOS)	\$0.00	V	\$48.00	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
12-23-02 01-07-03 01-23-03 (3 DOS)	97750- MT-52	\$236.50 (4 units @ \$86.00 on DOS 12-23-02 and 01-07-03 and 3 units at \$64.50 on DOS 01- 23-03)	\$0.00	V	\$43.00	IRO DECISION	IRO determined medical necessity for 1 unit on DOS 12-23-02 and 01-23-03. Reimbursement recommended in the amount of \$43.00 X 2 units = \$86.00. IRO did not determine medical necessity for date of service 01-07-03. No reimbursement recommended for date of service 01-07-03.
02-11-03 04-01-03 04-03-03 (3 DOS)	97750- MT	\$172.00 (2 units @ \$86.00 DOS 02-11-03, 1 unit @ \$43.00 DOS 04-01-03 and 04-03-03)	\$0.00	V	\$43.00	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
02-13-03 04-03-03	97750- MT-52	\$86.00 (2 units)	\$0.00	V	\$43.00	IRO DECISION	IRO determined services were not medically necessary. No

(2 DOS)		@ \$43.00 X 2 DOS)					reimbursement recommended
12-17-02	95851	\$80.00 (2 units)	\$0.00	U	\$36.00	IRO DECISION	IRO determined service was not medically necessary. No reimbursement recommended
02-11-03 04-01-03 ( 2 DOS)	95851	\$160.00 (1 unit @ \$40.00 X 4 units)	\$0.00	V	\$36.00	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended
02-06-03	99070	\$25.00 (1 unit)	\$0.00	V	DOP	IRO DECISION	IRO determined service was medically necessary. Recommend reimbursement in the amount of \$25.00
02-24-03	99070	\$8.00 (1 unit)	\$0.00	V	DOP	IRO DECISION	IRO determined service was medically necessary. Recommend reimbursement in the amount of \$8.00

<b>DOS</b>	<b>CPT CODE</b>	<b>Billed</b>	<b>Paid</b>	<b>EOB Denial Code</b>	<b>MAR\$</b>	<b>Reference</b>	<b>Rationale</b>
12-06-02 through 01-31-03 (15 DOS)	97250	\$645.00 (1 unit @ \$43.00 X 15 DOS)	\$0.00	V	\$43.00	IRO DECISION	IRO determined services were medically necessary. Recommend reimbursement in the amount of \$43.00 X 15 DOS = \$645.00
02-05-03 through 02-26-03 (7 DOS)	97250	\$301.00 (1 unit @ \$43.00 X 7 DOS)	\$0.00	V	\$43.00	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
12-06-02 through 02-03-03 (16 DOS)	97265	\$688.00 (1 unit @ \$43.00 X 16 DOS)	\$0.00	V	\$43.00	IRO DECISION	IRO determined services were medically necessary. Recommend reimbursement in the amount of \$43.00 X 16 DOS = \$688.00
02-05-03 through 02-26-03 (7 DOS)	97265	\$301.00 (1 unit @ \$43.00 X 7 DOS)	\$0.00	V	\$43.00	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
12-26-02 12-27-02 01-03-03 01-06-03 01-10-03 01-17-03 01-24-03 (7 DOS)	97110	\$980.00 (4 units @ \$140.00 X 7 DOS)	\$0.00	V	\$35.00	IRO DECISION	IRO determined services were medically necessary. Reimbursement recommended in the amount of \$140.00 X 7 DOS = \$980.00
12-30-02 01-13-03 01-15-03	97110	\$525.00 (3 units @ \$105.00	\$0.00	V	\$35.00	IRO DECISION	IRO determined services were medically necessary. Reimbursement recommended in the

01-21-03 02-03-03 (5 DOS)		X 5 DOS)					amount of \$105.00 X 5 DOS = \$525.00
01-31-03	97110	\$70.00 (2 units)	\$0.00	V	\$35.00	IRO DECISION	IRO determined services were medically necessary. Reimbursement recommended in the amount of \$70.00
12-09-02	97110	\$175.00 (5 units)	\$0.00	V	\$35.00	IRO DECISION	IRO determined service was medically necessary. Reimbursement recommended in the amount of 4 units X \$35.00 = \$140.00
12-11-02	97110	\$210.00 (6 units)	\$0.00	V	\$35.00	IRO DECISION	IRO determined service was medically necessary. Reimbursement recommended in the amount of 4 units X \$35.00 = \$140.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
12-05-02 02-17-03 02-19-03 02-20-03 02-26-03 (5 DOS)	97110	\$665.00 (4 units @ \$140.00 DOS 02-17-03 through 02-26-03 and 3 units @ \$105.00 DOS 12-05-02)	\$0.00	V	\$35.00	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
12-09-02 through 01-31-03 (11 DOS)	97150	\$297.00 (1 unit @ \$27.00 X 11 DOS)	\$0.00	V	\$27.00	IRO DECISION	IRO determined services were medically necessary. Reimbursement recommended in the amount of \$27.00 X 11 DOS = \$297.00
02-05-03 02-17-03 02-19-03 02-20-03 (4 DOS)	97150	\$108.00 (1 unit @ \$27.00 X 4 DOS)	\$0.00	V	\$27.00	IRO DECISION	IRO determined services were not medically necessary. No reimbursement recommended.
TOTAL		\$6,741.00					The requestor is entitled to reimbursement of <b>\$3,718.50</b>

The IRO concluded that treatment beyond 12 weeks post surgery for any treatment services (aside from therapeutic supplies for patient use at home) beyond 02-03-03 **were not** medically necessary. The IRO concluded that massage therapy (97124), electrical stimulation (97014),

diathermy (97024) from 11-11-02 through 02-03-03, office visit (99214) for 12-19-02 date of service only, myofascial release (97250) and joint mobilization (97265) between 12-06-02 and

02-03-03, therapeutic exercises no more than 4 units (97110) and group therapeutic procedures one unit (97150) between 12-06-02 and 02-03-03, muscle testing (97550-MT) dates of service 12-23-02, 01-07-03 and 01-23-03 one unit on 12-23-02 and 01-23-03, supplies (99070) dates of service 02-06-03 and 02-24-03 **were** medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees (**\$3,718.50**). 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.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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

On 01-20-04, 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	MAR\$	Reference	Rationale
01-28-03 through 03-24-03 8 DOS)	97110	\$1,085.00 (4 units @ \$140.00 X 7 DOS 02-24-03 through 03-24-03 and 3 units @ \$105.00 DOS 01-28-03)	\$0.00	D	\$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below.
01-29-03 through 03-26-03 9 DOS)	99213-52	\$225.00 (1 unit @ \$25.00 X 9 DOS)	\$0.00	D	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent submitted original denial reason, therefore reviewer cannot determine reason for denial. No reimbursement recommended.
01-29-03	97014	\$17.00 (1 unit)	\$0.00	D	\$15.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent submitted original denial reason, therefore reviewer cannot determine reason for denial. No reimbursement recommended.

01-29-03 through 03-26-03 (9 DOS)	97265	\$387.00 (1 unit @ \$43.00 X 9 DOS)	\$0.00	D	\$43.00	Rule 133.307 (g)(3)(A- F)	Requestor nor respondent submitted original denial reason, therefore reviewer cannot determine reason for denial. No reimbursement recommended.
02-24-03 through 03-26-03 (8 DOS)	97250	\$344.00 (1 unit @ \$43.00 X 8 DOS)	\$0.00	D	\$43.00	Rule 133.307 (g)(3)(A- F)	Requestor nor respondent submitted original denial reason, therefore reviewer cannot determine reason for denial. No reimbursement recommended.
03-05-03 through 03-26-03 (5 DOS)	97150	\$135.00 (1 unit @ \$27.00 X 5 DOS)	\$0.00	D	\$27.00	Rule 133.307 (g)(3)(A- F)	Requestor nor respondent submitted original denial reason, therefore reviewer cannot determine reason for denial. No reimbursement recommended.
03-20-03 03-21-03 (2 DOS)	97750- MT-52	\$86.00 (3 units @ \$64.50 and 1 unit @ \$21.50)	\$0.00	D	\$43.00	Rule 133.307 (g)(3)(A- F)	Requestor nor respondent submitted original denial reason, therefore reviewer cannot determine reason for denial. No reimbursement recommended.
04-01-03	99080- 73	\$15.00 (1 unit)	\$0.00	F	\$15.00	Rule 133.106(f)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
TOTAL		\$2,294.00					The requestor is not entitled to any reimbursement.

**RATIONALE:** Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

This Decision is hereby issued this 29<sup>th</sup> day of June 2004.

Debra L. Hewitt  
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 12-06-02 through 02-24-03 in this dispute.

This Order is hereby issued this 29<sup>th</sup> day of June 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

**REVISED 6/18/04**

January 14, 2004

MDR Tracking Number: M5-04-0674-01  
IRO Certificate # 5259

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by \_\_\_\_, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

\_\_\_\_ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to \_\_\_\_.

CLINICAL HISTORY

\_\_\_\_, a 46-year-old female, sustained an on the job injury to both wrists on \_\_\_\_, while working as a poultry eviscerator for \_\_\_\_\_. According to the records she felt her left wrist "pop", with acute onset of pain. She continued working for a while before seeking care. Subsequent treatment was initiated for left wrist pain, EMG confirmed left carpal tunnel syndrome. She underwent several months of conservative care before undergoing a left carpal tunnel release with DeQuervain's synovitis release on 3/28/01. She continued with problems and eventually presented to the \_\_\_\_ for chiropractic treatment of both wrists, as well as care for a separate work related injury to her lower back, which had occurred on 8/23/01. She was co-managed by \_\_\_\_ and \_\_\_\_\_. On 10/2/02 the patient underwent a right carpal tunnel release with \_\_\_\_\_.

A subsequent medical narrative report, dated 10/24/02, indicates that the patient was scheduled for a treatment program, three times per week for 6 weeks (18 sessions) consisting of a mixture of active and passive modalities. Subsequent report dated 12/17/02 indicates that she had completed 14 sessions of active and passive physical medicine between 10/30/02 and 12/11/02 for both right and left upper extremities, (along with three sessions between 8/7/02 and 12/12/02 for her lower back). Recommended continuation of care was for three times per week for 6 weeks, and then continued subsequently on an on-going fashion per reevaluation on 2/11/03.

Some of the services have been denied for medical necessity purposes (with some mixed issues) between 12/6/02 and 04/7/03, and so have been referred for IRO purposes.

Specific items in dispute include massage therapy, electrical stem-unattended, diathermy, office visits, myofascial release, joint mobilization, therapeutic exercises, therapeutic procedures, physical performance tests, office visits-evaluation, range motion measurements, supplies-materials.

Additional directions for specific services **not** in dispute include: 99213-52 for 1/21/03, 97110 for 1/28/03, 99213-52, 97014 and 97265 for 1/29/03, 99213-52 for 2/3/03, 99080-73 for 4/1/03, services 2/28/03 through 3/24/03.

#### REQUESTED SERVICE (S)

Massage therapy, electrical stimulation-unattended, diathermy, office visits, myofascial release, joint mobilization, therapeutic exercises, therapeutic procedures, physical performance tests, office visit-evaluation, ROM measurements, supplies-materials for dates of service 12/6/02 through 4/7/03.

#### DECISION

- Looking at the treatment course globally, there is no evidence to support necessity for any treatment beyond 12 weeks post surgery, i.e.: for any treatment services (aside from therapeutic supplies for patient use at home) beyond 02/03/03.
- Codes 97124 (massage therapy), 97014 (electrical stimulation) and 97024 (diathermy) are medically necessary through the time period of 11/11/02 through 2/3/03.
- Approve Code 99214 for date of service 12/19/02 only. Codes 99214 and 99215 were not medically necessary for any other dates within the range.
- In answer to the question of medical necessity for office visits billed in conjunction with this patient's treatment program, there is medical necessity established for only some of the services rendered. There is no evidence supporting the requirement for an expanded (99213) evaluation and management service/office visit on each patient encounter through the patient's therapy program, even with a - 52 modifier.
- Concerning 97750-MT billed on 12/23/02, 01/07/03 and 01/23/03: only one unit (for the right wrist) on 12/23/02 and 01/23/03 is medically necessary.
- Concerning code 95851, (wrist and shoulder ranges of motion) billed on 12/17/02: this service is an "un-bundled" component of an expanded, moderately complex patient (office visit) service billed on that same date and should not be considered for separate payment.
- Concerning the consumable supplies, 99070 billed on 02/06/03, and 02/24/03: these are medically necessary.

- Concerning codes 97250, 97265 (myofascial release and joint mobilization): these procedures are medically necessary between 12/06/02 and 02/03/03.
- Concerning codes 97110 and 97150 (therapeutic exercises and group therapeutic procedures): these services are partially medically necessary. There does not appear to be any necessity for more than four units of 97110 and one unit of 97150 per encounter between 12/06/02 and 02/03/03.
- Concerning 97110 and 97150 (therapeutic exercises and group therapeutic procedures): these services are partially medically necessary. There does not appear to be any necessity for more than four units of 97110 and one unit of 97150 per encounter.

#### RATIONALE/BASIS FOR DECISION

The patient apparently had had significant conservative treatment measures applied prior to the disputed timeframe, and, in fact, had been placed at maximum medical improvement by \_\_\_ on 7/14/02. It is reasonable to expect that no more than a post surgical course of care would be warranted to insure maximum recovery. Therefore, this course of care would be directed to rehabilitating the right wrist (which had been the area subjected to surgical intervention).

Unfortunately, there appear to be a number of different body areas and injuries being treated at the same time, so it is a little difficult to separate exactly what is being treated by which interventional measures.

It is fairly safe to say that following three months of care at three times per week, (with between 70 to 80 hours of one-on-one exercise instruction), the patient should have had adequate intervention to allow maximum therapeutic progression and discharge to a home exercise program.

The patient was essentially on a focused, post surgical rehabilitation/strengthening program for her right wrist, in addition to apparently ongoing treatment regime for her left wrist and lower back. This appeared, for all intents and purposes, to be progressing on an undeviating course. There is no evidence demonstrating the requirement for such intensive clinical monitoring, especially considering the degree of prior treatment intervention. Therefore, records do not support the need for additional office visits beyond a basic monitoring every two weeks. This is also especially true considering the degree of one-on-one intervention performed with this patient.

99214 would be appropriate when billed on 12/19/02 in order to incorporate the additional muscle testing and appropriate treatment plan restructuring / determine ongoing care requirements.

Functional testing (which includes range of motion and strength testing) is a necessary, objective standard to accurately assess functional compromise as well as to document progress in order to effectively manage the patient's course through a rehabilitation program, making modifications to the treatment plan as necessary. In this case, the patient has had extensive conservative treatment prior to surgical intervention, and was on a post-surgical rehabilitation course for the right wrist (having already being previously declared at MMI). There would appear to be reasonable rationale for muscle testing six weeks post surgery in order to determine suitability for more aggressively active exercise interventions on 12/23/02, with an updated progress one month later. There is no rationale offered for, or any clinical deviation implemented as a result of, further muscle testing.

According to CCI edit requirements, 95851 (range of motion) is a mutually exclusive code when billed in conjunction with a 99214 level of service. It is considered to be a component of that service and should not be billed separately.

The patient had a significant upper extremity (wrist) disorder, resulting in functional compromise and pain. It is appropriate to offer some analgesic balm as a noninvasive pain reducing measure. It is also a standard of care to provide separate electrode patches for patients for the sake of hygiene.

These seem to be acceptable procedures performed in conjunction with an active therapy program for the type of injury sustained by this patient.

This patient was, as mentioned, on a post surgical rehabilitation course for her right wrist. She had previously undergone extensive conservative interventional measures. There does not seem to be any indication as to why more than an hour of one-on-one exercises would be required for such a rehabilitation course per encounter. One unit of group activity measures would also be sufficient to provide any sort of pre-exercise "warm-up".

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

#### YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the 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 **10** (ten) calendar days of your receipt of this decision (20 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 **20** (twenty) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), 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 18<sup>th</sup> day of June 2004.