

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-04-6408.M5**

MDR Tracking Number: M5-04-0946-01

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, 133.307 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 12-01-03.

The IRO reviewed therapeutic activities, hot/cold pack therapy, electrical stimulation-unattended, neuromuscular re-education, myofascial release and extended office visits rendered from 12-26-02 through 02-13-03 that was 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. Consequently, the requestor is not owed a refund of the 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 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 02-24-04, 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	Reference	Rationale
1-13-03 through 3-14-03 (14 DOS)	97530	\$490.00 (1 unit @ \$35.00 X 14 DOS)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$35.00 X 14 DOS = \$490.00
2-17-03 through 3-14-03 (13 DOS)	97010	\$143.00 (1 unit @ \$11.00 X 13 DOS)	\$0.00	NO EOB	\$11.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$11.00 X 13 DOS = \$143.00
2-17-03 through 3-14-03	97014	\$195.00 (1 unit @	\$0.00	NO EOB	\$15.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement

(13 DOS)		\$15.00 X 13 DOS)					recommended in the amount of \$15.00 X 13 DOS = \$195.00
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DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
2-21-03 through 3-13-03 (7 DOS)	97112	\$245.00 (1 unit @ \$35.00 X 7 DOS)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$35.00 X 7 DOS = \$245.00
3-14-03	97540	\$37.00 (1 unit)	\$0.00	NO EOB	\$32.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$32.00
3-14-03	99214	\$71.00 (1 unit)	\$0.00	NO EOB	\$71.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$71.00
TOTAL		\$1,181.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$1,176.00

### 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 01-13-03 through 03-14-03 in this dispute.

This Findings and Decision and Order are hereby issued this 28th day of April 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

February 24, 2004

### NOTICE OF INDEPENDENT REVIEW DECISION Amended Determination

**RE: MDR Tracking #: M5-04-0946-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission

(TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The \_\_\_ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

#### Clinical History

This case concerns a male who sustained a work related injury on \_\_\_. The patient reported that while at work he was using a machine wood saw when he cut his right index finger. The initial diagnosis for this patient was a near amputation of the right index fingertip. The patient underwent a pin fixation of the middle phalanx fracture, a repair of the ulnar digital nerve and a closure of a 4 cm laceration on 5/21/02. An x-ray report dated 7/30/02 indicated an oblique fracture line passing through the shaft of the middle phalanx that had healed. On 8/16/02 the patient underwent a manipulation of the PIP and DIP joint and repair of the ulnar digital nerve using a sterile nerve graft. The diagnoses for this patient have included status post open fracture index finger with subsequent digital nerve injury. Postoperatively the patient had been treated with therapeutic activities, moist heat, and electrical stimulation.

#### Requested Services

Therapeutic activities, hot/cold pack therapy, electrical stimulation-unattended, neuromuscular reeducation, myofascial exercises, extended office visit, from 12/26/02 through 2/13/03.

#### Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

#### Rationale/Basis for Decision

The \_\_\_ chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his right index finger on \_\_\_. The \_\_\_ chiropractor reviewer also noted that the patient was diagnosed with near amputation of the right index fingertip and underwent a pin fixation of the middle phalanx fracture, repair of the ulnar digital nerve and a closure of a 4cm laceration on 5/21/02. The \_\_\_ chiropractor reviewer further noted that the patient underwent a manipulation of the PIP and DIP joint and repair of the ulnar digital nerve using a sterile nerve graft. The \_\_\_ chiropractor reviewer indicated that the patient underwent 28 treatments from 10/16/02 through 12/23/02 without any documented

improvement. The \_\_\_ chiropractor reviewer noted that the patient continued treatment from 12/26/02 through 2/13/03. However, the \_\_\_ chiropractor reviewer explained that there was no documentation supporting that the patient had benefited from this treatment. The \_\_\_ chiropractor reviewer also explained that the treatment rendered to this patient beginning 12/26/02, could have been performed by the patient at home. Therefore, the \_\_\_ chiropractor consultant concluded that the therapeutic activities, hot/cold pack therapy, electrical stimulation-unattended, neuromuscular reeducation, myofascial exercises, extended office visit, from 12/26/02 through 2/13/03 were not medically necessary to treat this patient.

Sincerely,

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