

MDR Tracking Number: M5-04-1731-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on February 13, 2004.

The IRO reviewed joint mobilization, manual traction, myofascial release, ultrasound, therapeutic exercises, electrical stimulation, paraffin bath, office visits, hot/cold pack therapy, manual therapy, chiropractic manual treatment from 03/04/03 through 09/11/03 that was denied based upon "V".

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

The IRO determined that therapeutic exercises, hot/cold pack, manual therapy and spinal manipulation from 09/03/03 through 09/11/03 were medically necessary. It was also determined by the IRO that all office visits, joint mobilization, manual traction, myofascial release, ultrasound, electrical stimulation and paraffin baths were not medically necessary. For dates of service 03/04/03 through 09/02/03 the IRO determined therapeutic exercises, hot/cold therapy, manual therapy technique and spinal chiropractic manual treatment were not medically necessary.

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.

On May 13, 2004, 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.

- CPT Code 99080-73 for dates of service 03/13/03 and 05/29/03 denied as "V". Per Rule 129.5 the TWCC-73 is a required report and MDR has jurisdiction over these matters. Per Rule 133.106(f)(1) reimbursement in the amount of \$30.00 (\$15.00 x 2) is recommended.

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 outlined above as follows:

- In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- In accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);

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 09/03/03 through 09/11/03 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 4th day of November, 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mfEnclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

April 30, 2004

Amended Letter 09/30/04

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-1731-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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, and licensed in 1986 and provides health care to injured workers. TMF's 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 TMF 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 27 year old male suffered an injury on ___ to the cervical region, left hand and left thumb. On 12/13/03, her EMG/NCV revealed left acute and chronic carpal tunnel syndrome. On 03/31/03, the MRI of the left wrist and thumb were within normal limits. On 07/21/03, the patient underwent a carpal tunnel release on the left. On 12/09/03, the medical record documentation states that her EMG/NCV on the left upper extremity was performed. There was not evidence of recurrent carpal tunnel syndrome and showed mild chronic C5-C6 radiculopathy with nerve damage. The treatment plan included splinting, Vioxx. Myofascial release therapeutic range of motion (ROM) exercises and electrical stimulation

Requested Services

Joint mobilization, manual traction, myofascial release, ultrasound, therapeutic exercises, unattended electrical stimulation, special reports, paraffin bath, level II office visit, level III office

visit, level V office visit, hot/cold pack therapy, manual therapy technique and spinal chiropractic manual treatment from 03/04/03 through 09/11/03

Decision

It is determined that therapeutic exercises, hot/cold pack, manual therapy and spinal manipulation from 09/03/03 through 09/11/03 were medically necessary. It is determined that office visits (all levels), special reports, joint mobilization, manual traction, myofascial release, ultrasound, unattended electrical stimulation and paraffin baths were not medically necessary. The therapeutic exercises, hot/cold therapy, manual therapy technique and spinal chiropractic manual treatment from 03/04/03 through 09/02/03 were not medically necessary.

Rationale/Basis for Decision

The patient initially went to the chiropractor for evaluation and treatment of neck pain, left wrist pain and left thumb pain on _____. The treatment plan revealed that the patient was treated with office visits and with joint mobilization, manual traction, unattended electrical stimulation, myofascial release, ultrasound and therapeutic exercises in varying combinations. The joint mobilization, myofascial release, manual traction and therapeutic exercises (except from 09/03/03 through 09/11/03) were not medically necessary. The patient had already been under treatment since _____ without any significant evidence of clinical benefit from treatments. The use of ultrasound is not indicated for carpal tunnel syndrome. Therapeutic exercises after hand surgery are clinically relevant to accelerate recovery. The unattended electrical stimulation and paraffin baths were not medically necessary. Conservative treatment of carpal tunnel syndrome includes the use of wrist splints, activity modification, removal of constrictions and non-steroidal anti-inflammatory drugs.

Therefore, it is determined that therapeutic exercises, hot/cold pack, manual therapy and spinal manipulation from 09/03/03 through 09/11/03 were medically necessary. However, the joint mobilization, manual traction, myofascial release, ultrasound, unattended electrical stimulation and paraffin baths were not medically necessary. The therapeutic exercises, hot/cold therapy, manual therapy technique and spinal chiropractic manual treatment from 03/04/03 through 09/02/03 were not medically necessary.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment
GBS:lr