

MDR Tracking Number: M5-04-1831-01

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 02/23/04.

The IRO reviewed an office visit (99213), conductive paste or gel (A4558), and a treating doctor exam (99455-V5-WP) rendered from 08/01/03 through 08/19/03 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. 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 April 29, 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 97750-FC (8) for date of service 08/01/03. Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOBs. In reviewing the fee dispute issues the table of disputed services listed CPT Code 97750-FC twice. The requestor's representative was contacted, via e-mail on 9/28/04, and the correct number of units is 8. Per Rule 134.202(e)(4) and the Medicare Fee Schedule reimbursement in the amount of \$295.52 ($\$29.55 \times 125\% = \36.94×8) is recommended.
- CPT Code 99080-73 for date of service 08/01/03. The carrier denied this code a V for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO Review. The Medical Review Division has jurisdiction in the matter and therefore, reimbursement in the amount of \$15.00 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 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 Order is applicable to dates of service 08/01/03 through 08/19/03 in this dispute.

This Decision & Order is hereby issued this 30th day September 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

Enclosure: IRO Decision

April 22, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter**

RE: MDR Tracking #: M5-04-1831-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
Case #:

___ 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 female who sustained a work related injury on -----. The patient reported that while at work she sustained a repetitive motion injury to her left arm wrist and hand. The initial diagnoses for this patient included radial nerve compression lesion, radial styloid tenosynovitis, ulnar nerve compression lesion, other lesions of medial nerve, other tenosynovitis of wrist and hand. The patient was started on a course of physical therapy. On 3/24/03 the patient underwent an MRI of the left wrist and elbow that indicated crowding of flexor tendons with carpal tunnel, anterior bowing of flexor retinaculum and comparative prominence of medial nerve within carpal tunnel may reflect the clinical carpal tunnel syndrome, and interfluid signal within the common flexor tendon at the medial humeral epicondylar insertion. An EMG dated 4/11/03 indicated no electrophysiological evidence of cervical radiculopathy, brachial plexopathy or digital mononeuropathy. The patient continued treatment with therapy and rehabilitation, and had also participated in a work hardening/conditioning program. The treating diagnosis for this patient included carpal tunnel syndrome.

Requested Services

Office visit, conductive paste or gel, and treating doctor exam from 8/1/03 through 8/19/03.

Decision

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

Rationale/Basis for Decision

The chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her left arm, wrist and hand on -----. The chiropractor reviewer also noted that the diagnoses for this patient have included radial nerve compression lesion, radial styloid tenosynovitis, ulnar nerve compression lesion, and other lesions of medial nerve, other tenosynovitis of wrist and hand. The chiropractor reviewer further noted that the patient had undergone an EMG testing and had been treated with physical therapy, rehabilitation, and a work hardening/conditioning program. The chiropractor reviewer indicated that the patient underwent a functional capacity evaluation at the end of 8 weeks participating in a work hardening program. The chiropractor reviewer explained that a functional capacity evaluation at this time would be appropriated to evaluate the patient's progress and determine if the patient is able to return to work. The chiropractor reviewer noted that on 8/19/03 the patient underwent an impairment rating evaluation. The chiropractor reviewer explained that this evaluation was appropriate to determine the maximum medical improvement for this patient. Therefore, the chiropractor consultant concluded that the office visit, conductive paste or gel, and treating doctor exam from 8/1/03 through 8/19/03 were medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department