

MDR Tracking Number: M5-04-1993-01

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 March 4, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, massage and aquatic therapy were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 12-16-03 to 12-30-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 26th day of May 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

May 10, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

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IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The documentation denotes that this 58-year-old woman sustained an injury while at work on ___. The mechanism of injury is noted as: "Some of the students slipped and fell from the top bleacher, pushing the patient over to the floor." She was sitting on the last bottom bleacher while taking a class picture.

She initially underwent treatment by ___ four times. She did not seek care again until she presented at ___ on ___, some five months after the accident. No explanation was given for this gap. The presenting symptoms and clinical findings all focused around her original area of the left upper extremity and now some findings on the right upper extremity. The clinical findings were minimal and uncomplicated. There were no neuro-deficits noted. There were only some decreased range of motion with palpatory pain and tenderness. The only positive orthopedic finding was reverse Phalens on the left. Diagnosis was CTS and S/S of the wrist/hand. An interim report of 07/15/03 indicates the patient's VAS was 9/10, but indicated slight improvement. This was over three months from the first report and over eight months post-injury. The patient now reported injuries of the neck, mid back and lower back. There were no causality and/or related statements as to these new complaints within the documentation. There were no neuro-deficits noted and only a few positive ortho tests were noted. By this time, the patient had had an MRI of the wrist with findings of "mild degenerative change in the triangular fibrocartiliginous complex." The next follow-up was on 10/22/03. They presented with a VAS of 8/10. The doctor suggested MRIs of the neck and low back. By then, the patient had had a Designated Doctor exam on 10/20/03 and was rated at MMI with an impairment of 10%. The next follow-up was on 12/16/03. The patient presented with a VAS of 6/10. MRIs showed mostly findings consistent with degenerative findings of a 58-year-old female. By 01/05/04, the patient exhibited a VAS of 3/10 and was released to PRN care.

DISPUTED SERVICES

Under dispute is the medical necessity of office visits, massage and aquatic therapy from 12/16/03 through 12/30/03.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Regarding the disputed office visits, it is obviously appropriate to use an established patient code after the initial encounter, as was the case here. The question now would be, does the level of service performed meet the criteria of the code used? The provider used a 99214 code for this particular case on 12/16/03, a code that denotes a moderate to high severity with a prognosis indicating an uncertain outcome and/or increased probability (moderate) or high probability of severe, prolonged functional impairment.

Morbidity is rated at moderate to extreme and a mortality of moderate to high. These are highly unlikely considering this patient's findings and diagnosis.

The next issues have to do with the three components: history, physical exam and decision-making. A 99214 has a chief complaint, extended history of present illness, an extended review of systems and a pertinent past history, family history and social history. This claim only documents a chief complaint, an extended history of the present illness and no review of systems and no past history with no family or social history. Therefore, in history he did not meet the requirements to justify the use of the 99214 code. As for the exam, it should be an extended exam of affected areas or organ systems and other symptomatic or related organ systems. The exam performed was not to this level. Therefore, in exam he did not meet the requirements to justify the use of 99214. With regards to decision-making, he did not meet the minimum two of three areas to justify the use of 99214. A 99214 has a moderately complex level of decision-making. This includes multiple diagnoses/management options, moderate review/analysis: amount/complexity and a moderate risk of complications (morbidity/mortality). Therefore, based on all these factors, at best the most appropriate level of established patient service in this case would have been a 99212.

Subsequent dates of service on 12/29/03 and 12/30/03 appear to meet the requirements for a 99213 level of service, however the reviewer notes that all of the findings are focused around the neck and low back while the assessment is CTS and S/S of the wrist, so one can see that these are not consistent with each other.

The areas of the neck and low back came very late in the case and were never shown to be causally related to the incident. Therefore, any care directed to these areas would be considered medically unnecessary. These areas are more related to other comorbidities (age and degenerative changes). There is also the question of the large gap in care initially with regards to the wrist. This is not addressed in the record either. There were virtually no clinical findings initially with regards to the wrist and the severity of the injury was minimal. The findings of the MRI months later are only mildly degenerative in nature. Overall, nothing adds up in this case. The services rendered in this case far exceed the clinical documentation that would support them. It's not about guidelines you have to have clinically significant findings that are substantiated and correlated before guidelines can be applied.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,