

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 9, 2004.

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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The physician patient phone call and problem focused office visits on 03-10-03 and 99213 and/or 99211 on a maximum semi-monthly schedule **were found** to be medically necessary. The therapeutic procedure, myofascial release, joint mobilization, neuromuscular re-education, electrical muscle stimulation, physical treatment 1 area massage, and physical medicine treatment, one area, training activities in daily living from 03-05-03 through 06-20-03 were found **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 03-10-03 through 06-20-03 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 2nd day of August 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 14, 2004

RE: **AMENDED DECISION**

MDR Tracking #: M5-04-2039-01

IRO Certificate #: 5242

___ 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 ___ 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 proposed 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 Chiropractic reviewer who has an ADL certification. The reviewer 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 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

Records Reviewed:

- Correspondence Letter dated 4/20/04 from _____
- Correspondence Letter dated 5/20/03 from _____
- Request for Reconsideration Letter dated 10/28/03 from _____
- Daily Progress Notes dated 11/8/02 - 5/30/03
- Productivity Index dated 5/27/03 and 5/29/03
- Daily Exercise Sheet dates 5/29/03
- Initial Evaluation for Physical Therapy 12/10/02 and 5/21/03
- Digital Motion X-Ray of wrist and right thumb dated 4/22/03
- Letter of Dispute Resolution from ___ dated 5/13/03
- Functional Capacity Evaluation dated 3/18/03
- Nerve Conduction Study Report dated 1/6/03 from _____
- Designated Doctor TWCC 69 dated 2/27/03 from _____
- Operative Report dated 11/13/02 from _____
- Initial Medical Report dated 10/24/02 from _____
- Office Notes from ___ dates 11/5/02 – 3/13/03

The claimant is a 30-year-old female who injured her right thumb while working for ___ when a box fell and forcefully abducted her thumb. It appears that the claimant had surgical repair of the right thumb metacarpophalangeal joint radial collateral ligament performed by ___ on 11/13/02 after poor response to conservative care. The claimant had a Digital Motion x-ray of the right wrist and thumb performed on 4/22/03 which revealed right thumb second metacarpal displacement with arthritic changes and a black pin-head size artifact there is scaphoid fixation on ulnar deviation. There was a nerve conduction study performed by ___ on 1/6/03, which revealed slowing of the right motor nerve conduction velocity of the right ulnar nerve. The claimant had a Designated Doctors Evaluation performed on 2/27/03 by ___ who determined the claimant at maximum medical improvement with a 3% whole person impairment. The claimant has had extensive post surgical rehabilitation at ___ under the direction of ___, which has included passive and active modality therapy from 11/8/02 – 5/30/03. It does appear that the claimant has participated in a work hardening program.

Requested Service(s)

Therapeutic Procedure, Myofascial Release, Joint Mobilization, Neuromuscular Re-Education, Established Office Visits, Phone Call Physician to Patient, Physical Treatment 1 area, Traction Manual, Electrical Muscle Stimulation, Physical Medicine Treatment 1 area, Training Activities of Daily Living, Established Outpatient L2 Problem Focus History and Evaluation, Physical Treatment 1 area Massage for dates of service 3/5/03-6/20/03.

Decision

I agree with the insurance carrier that therapeutic procedure, manual traction, myofascial release, joint mobilization, neuromuscular re-education, electrical muscle stimulation, physical treatment 1 area massage, physical medicine treatment, one area, and training activities of daily living are not reasonable and necessary. I disagree with the insurance carrier regarding the physician-patient phone call. Problem focused office visits including 99213 and/or 99211 are found to be reasonable and necessary on a maximum semi-monthly schedule.

Rationale/Basis for Decision

These treatments far exceed the recommendation of the Official Disability Guidelines. The claimant apparently had a surgical procedure of the right thumb to repair metacarpophalangeal joint radial collateral ligament on 11/13/02 and was determined at maximum medical improvement by designated doctor, ___ with 3% whole person impairment on 2/27/03. The above treatment 4 months post surgery far exceeds the recommendation of The Official Disability Guidelines which allows 9 physical therapy visits over a 8 week period with a gradual fade to an active self-directed home physical therapy. It would seem reasonable for the claimant to follow-up with her treating physician 1-2 times monthly to follow-up with the claimant's progress with home therapy. Therefore, billing an Established Outpatient Office Visit 99213 and/or 99211 is reasonable and necessary for up to 1-2 times monthly for follow-up office visit if a detailed examination is performed and documented. I disagree with the carrier position on the Phone Call by the Physician to the Patient for the physician was returning the patients phone call and this was documented in the provided records.