MDR Tracking Number: M5-04-3251-01
Previous #: M5-04-0699-01

TEXAS WORKERS' COMPENSATION COMMISSION
MEDICAL REVIEW DIVISION, MS-48
MEDICAL DISPUTE RESOLUTION
AMENDED FINDINGS AND DECISION

The Medical Review Division reviewed the decision of the Independent Review Organization (IRO) in the captioned medical dispute and concludes the dispute with the enclosed Amended Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Amended Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within **20** (twenty) days of your receipt of this Amended Decision (28 Tex. Admin. Code § 148.3). This Amended Decision is deemed received by you 5 (five) days after it was mailed and the first working day after the date this Amended Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P. O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Amended Decision should be attached to the request.

The party appealing the Division's Amended Decision and Order shall deliver a copy of this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Amended Findings and Decision and Order was placed in the insurance carrier representative's box and mailed to the requestor applicable to Commission Rule 102.5 this _____ day of _____, 2004. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Amended Decision was placed in the carrier representative's box.

Signature of Commission Employee: _____

Printed Name of Commission Employee: _____

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 11-04-03. In accordance with Rule 133.307(d)(1), a dispute on a carrier shall be considered timely if it is filed with the division no later then one year after the dates of service in dispute therefore, date of service 10-31-02 in dispute is considered untimely and will not be address in this review. In addition requestor withdrew date of service 12-11-02 for 99070.

This Amended Findings and Decision supersedes all previous decisions rendered in this medical dispute involving the above requestor and respondent.

The Medical Review Division Decision of April 30, 2004 was withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of May 27, 2004. A copy of the Notice of Withdrawal is reflected in the Commission Case file. An Order was issued in favor of the respondent.

The Respondent Appealed the Order to the Chief Clerk of Proceedings based upon incorrect reimbursement amount for 97750-MT and correction of denial codes for fee issues for date of service 11-19-02 resulting in this issuance of the Notice to Withdraw.

The IRO reviewed office visits, therapeutic exercises, group therapeutic procedures, joint mobilization, myofasical release rendered from 11-06-02 through 12-23-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for one office visit every two weeks with a maximum of four, 99214 on 11-19-02, myofasical release, joint mobilization, therapeutic exercises and group therapeutic procedures. However, the Medical Review Division also determined that **the requestor did not prevail** on the issues of medical necessity for office visits exceeding the maximum of four allowed office visits. 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 01-12-04, 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**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
11-04-02	99070	$25.00	0.00	F	DOP	General GR IV	All TENS supplies shall be billed with code E1399 therefore reimbursement is not recommended.

11-19-02	99080-73	$15.00	0.00	NF	DOP	Per Rule 133.106(b) and (f)(3)	Work Status report was not submitted unable to confirm service rendered therefore, reimbursement is not recommended
	95851	$40.00	0.00	F	$36.00	MFG, MGR (I)(E)(4)	Report submitted to support delivery of service. Recommended Reimbursement $36.00
	97750MT (3 units)	$129.00	0.00	F	$43.00	MFG MGR (I)(E)(3)	97750MT will be reimbursed per body area tested therefore recommended reimbursement $43.00
11-22-02	99213	$50.00	0.00	M	$48.00	MFG, E & M GR(IV)(C)(2)	Per EOB and requestor service have been paid. Therefore additional reimbursement is not recommended.
11-25-02	97750MT (3 units)	$129.00	0.00	F	$43.00	MFG MGR (I)(E)(3)	
	99080	$15.00	0.00	F	DOP	Per Rule 133.106(b) and (f)(3)	Report was not submitted to support delivery of service. Reimbursement is not recommended
12-26-02	97750MT (3 units)	$129.00	0.00	F	$43.00	MFG MGR (I)(E)(3)	97750MT will be reimbursed per body area tested therefore Recommended Reimbursement $43.00
01-31-03	99214	$75.00	0.00	F	$71.00	MFG, E & M GR(IV)(C)(2)	Soap notes support delivery of service. Recommended Reimbursement $71.00
TOTAL		$607.00					The requestor is entitled to reimbursement of **$193.00** in addition to the disputes resolved by the IRO

This Amended Decision is hereby issued this __15_____ day of July 2004.

Medical Dispute Resolution Officer
Medical Review Division

AMENDED 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 11-06-02 through 01-31-03 in this dispute.

This Amended Order is hereby issued this __15__ day of July 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 4/26/04

TWCC Case Number:	
MDR Tracking Number:	M5-04-0699-01
Name of Patient:	
Name of URA/Payer:	SCD Back & Joint Clinic, Ltd.
Name of Provider: (ER, Hospital, or Other Facility)	SCD Back & Joint Clinic, Ltd.
Name of Physician: (Treating or Requesting)	David N. Bailey, DC

December 31, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Notice of Independent Review Determination
Sincerely,
Michael S. Lifshen, MD
Medical Director cc: TWCC

REVISED 4/26/04

RE: _____

CLINICAL HISTORY

_____ , a 38-year-old male, sustained an on the job injury to his right wrist while working as a construction worker for ___ Construction Company. He fell onto an outstretched arm while jumping across a ditch. As he fell, he hyper-extended his wrist radially. He presented initially to the emergency room where x-rays were taken, then sent to Philip Holzknecht, MD for orthopedic evaluation. Diagnosis was right wrist scapholunate ligament tear, with a planned follow-up with a hand surgeon. He then saw Douglas Stauch, M.D., an orthopedist who diagnosed him with a right wrist strain, superimposed upon an old severe fracture of the right wrist. X-rays revealed status post fracture of the distal radius / ulna with a wavy deformity of both bones distally, disruption of the scapholunate joint, status post fracture of styloid, loose fragment with rounded smooth edges and irregularity of distal radius and deformity of the navicular with apparently healed old fracture. Initial treatment was a wrist splint, NSAIDS, and patient was taken off work. No improvement was noticed in six weeks so a referral for electro-diagnostic studies was made to Randall Light, M.D. at the end of September 2002. Right ulna and median nerve conduction studies are within normal limits and EMG of the intrinsic muscles of the right hand was normal. Assessment was right wrist and hand pain of musculoskeletal origin with nonspecific parasthesias. Recommendation was continued orthopedic treatment. Dr. Stauch then made a referral to Dr. Richardson for further care as he no longer felt he could help the patient. Dr. Richardson saw the patient on 10/7/02 and injected "the lunotriquetral strain", and referred him for a wrist arthrogram. This revealed a complete disruption of the scapholunate ligament but with no evidence of triquetro-lunate ligament tear. At this point, the patient changed treating doctors to David Bailey, D.C. and was seen 10/31/02. Presenting complaints were of continued right wrist pain, with moderate weakness and intermittent numbness/tingling causing difficulty with writing, buttoning, bathing, carrying grocery bags. Dr. Bailey's impression was of right wrist sprain/strain with ulnar nerve neuritis. He maintained the patients 'off work' status and placed him on a comprehensive treatment regime consisting of mobilization/soft tissue work to the right upper extremity, with adjunctive physiotherapeutic modalities and one-on-one therapeutic and group

exercises. He prescribed some analgesic balm and an ice pack. MRI was ordered on 11/22/02 however this was a limited study due to patient motion, revealing widening of the scapholunate space with a tear of the scapholunate ligament. The patient was seen for designated doctor purposes on 11/26/02, by AJ Mohabeer, M.D. He found that the patient was at MMI with a 2% whole person impairment rating. This was disputed by the treating doctor.

Some of the services have been denied for medical necessity purposes (with

some mixed issues) between 11/6/02 and 12/23/02, and so have been referred for IRO purposes.

REQUESTED SERVICE(S)
Ovs, therapeutic exercises, grp therapeutic procedures, joint mobilization, myofascial release for dates of service 11/6/02 through 12/23/02.

DECISION
●In answer to the question of medical necessity for office visits billed in conjunction with the patient's treatment program, there is medical necessity established for only *some* of the services rendered. There is no evidence supporting the requirement for an expanded (99213) evaluation and management service / office visit on each patient encounter through the patient's therapy program. This should be reduced to one (1) office visit (99213) every two weeks (maximum of 4 X 99213) between 11/6/02 and 12/23/02.

Rationale:
The patient was essentially on a focused rehabilitation/strengthening program for the right wrist, which for all intents and purposes was progressing on an undeviating course. There was no evidence in the documentation suggesting the requirement for additional office visits beyond a basic monitoring every two weeks.

●Concerning service 99214 billed 11/19/02 and 01/31/03, there is establishment for the medical necessity for one (1) 99214 level of service on 11/19/02.

Rationale:
The 99214 level of service is appropriate on 11/19/02, integrating the results of the functional assessment and updated testing, and to determine ongoing care requirements.

●Concerning codes 97250, 97265 (myofascial release and joint mobilization) billed on 12/23/02; these procedures are medically necessary.

Rationale:
These seem to be acceptable procedures performed in conjunction with an active therapy program for the type of injury sustained by this patient.

●Concerning codes 97110 and 97150 (therapeutic exercises and group therapeutic procedures); these services are medically necessary.

Rationale:

This patient sustained a fairly significant injury to his right wrist, involving a carpal ligamentous disruption, superimposed upon a previously significant traumatic (although non-compensable) condition. He had failed previous interventionary measures. He was already at somewhat of a chronic presentation by the time he sought care with Dr. Bailey. This tends to indicate that this was more than just an "average" wrist sprain/strain injury. Considering his occupation as a laborer, it would also indicate that the level/degree of rehabilitation required was somewhat more important in order for this gentleman to have any success at returning to his previous occupation. The documentation is clear in demonstrating that improvement was gained through this therapy program. As such, although the number of units billed on each occasion may seem somewhat excessive for rehabilitation of a wrist, the services were adequately documented

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.