

MDR Tracking Number: M5-04-3728-01

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 June 28, 2004.

The IRO reviewed 99213 – office visits, 97250 – myofascial release, 97014 – unattended electrical stimulation, 97010 – hot/cold packs, 97035 – ultrasound, 20550 – injection(s); single tendon sheath, or ligament, aponeurosis, J3490 – Unclassified drugs, A4209 – Syringe with needle, sterile 5 cc or greater rendered from 07/08/03 through 09/11/03 that was 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. 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 September 8, 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 date of service 08/19/03. The carrier denied this CPT code with 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 this matter and, therefore, per Rules 129.5 and 133.106(f)(1) 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 07/08/03 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 Decision & Order is hereby issued this 30th day September 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO Decision

August 25, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3728-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- 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 who is familiar with the with the condition and treatment options at issue in this appeal. 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 ----- . An EMG performed on 11/15/99 was reported to have shown right carpal tunnel syndrome. The patient underwent a series of injections and treatment with a neuromuscular stimulator and subsequently underwent right carpal tunnel release on 8/3/00. Postoperatively the patient was treated with therapy. On 10/18/01 the patient was evaluated and found to have bilateral shoulder impingement syndrome. On 3/4/02 x-rays of the left and right shoulder, right and left elbow, left and right

forearm, left and right wrist, and left and right hand were reported as normal. An EMG performed on 4/6/02 was reported to have shown bilateral carpal tunnel syndrome. The patient was treated with further injections and a therapy program. On 6/25/02 the patient underwent neurolysis of the median nerve, tenosynovectomy of the flexor tendons of the palms and wrist and release of distal forearm flexor retinaculum on 6/25/02 secondary to a diagnosis of right carpal tunnel syndrome with flexor tenosynovitis. The patient continued with postoperative therapy. On 10/2/02 the patient underwent a neurolysis of the left median nerve, left transverse carpal ligament release and tenosynovectomy of the flexor tendons of the palm wrist and release of distal forearm flexor retinaculum. Postoperatively the patient was treated with therapy and subsequently underwent injections.

Requested Services

Office visits, myofascial release, unattended electrical stimulation, hot/cold packs, ultrasound, injection; single tendon sheath, or ligament, aponeurosis, unclassified drugs and a syringe with needle, sterile 55cc or greater from 7/8/03 through 9/11/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Chiropractic treatment notes 7/15/02 – 6/17/04
 2. Daily Treatment logs 8/26/02 – 5/23/03
 3. Treatment Notes 7/20/02 – 1/8/04
 4. Prescriptions 7/20/02 – 1/8/04
 5. DO treatment notes 4/29/03 – 6/12/03
 6. PA treatment notes 8/27/03 – 6/10/04
 7. Daily treatment logs 6/24/03 – 1/27/04
 8. FCE 6/29/04
- Evaluation 12/1/03 – 4/19/04

Documents Submitted by Respondent:

1. Medical record review 1/5/04

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 on -----. The ----- chiropractor reviewer also noted that the patient underwent right carpal tunnel release on 8/3/00 followed by postoperative therapy. The ----- chiropractor reviewer indicated that follow up care for this patient's condition was medically necessary. The ----- chiropractor reviewer explained that continued care was required to help prevent this patient from regressing. The ----- chiropractor reviewer further explained that the patient responded well to treatment rendered. Therefore, the ----- chiropractor consultant concluded that the office visits, myofascial release, unattended electrical stimulation, hot/cold packs,

ultrasound, injection; single tendon sheath, or ligament, aponeurosis, unclassified drugs and a syringe with needle, sterile 55cc or greater from 7/8/03 through 9/11/03 were medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department