

MDR Tracking Number: M5-04-3794-01

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 January 20, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of 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 \$650.00** 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 the only issue** to be resolved. The therapeutic activities (97530) on 04-01-03, 04-02-03, 04-04-03, 04-07-03 and 04-08-03 and therapeutic exercises (97110) on 04-14-03 **were found** to be medically necessary. The electrical stimulation, unattended (97014) on 04-01-03, 04-02-03, 04-04-03 and 04-07-03 and the office visit (99213) on 04-08-03 **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 04-01-03 through 04-08-03 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 18<sup>th</sup> day of August 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

PR/pr

08/10/2004

David Martinez  
TWCC Medical Dispute Resolution  
7551 Metro Center Suite 100  
Austin, TX 78744

Patient:  
TWCC #:  
MDR Tracking #: M5-04-3794-01  
IRO #: 5284

Specialty IRO 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 Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty 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.

This case was reviewed by a licensed Chiropractor with a specialty in rehabilitation. The Specialty IRO 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 Specialty IRO 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

\_\_\_ was injured in \_\_\_ while working for \_\_\_. He was provided with a fusion to the cervical spine shortly following the accident. However, records of treatment prior to 9/12/02 are scarce as provided by the requestor and respondent. The patient sought the care of Dr. H, MD and Dr. S, MD. A cervical MRI and left shoulder MRI were performed as was neurodiagnostic testing on 10/18/02. The left median nerve was found to have severe neuropathy at the wrist while the right median nerve was found to have moderately severe neuropathy at the wrist. All other nerves were reported as normal. Per the 10/10/02 note of Dr. H, physical therapy did not help his shoulder pain much. Dr. H advocated an endoscopic release of the carpal tunnel. The CTS release was performed on 12/9/03. As of the 1/9/03 office note, Dr. H notes the patient is to perform ROM exercises and to 'give it more time'. The 2/20/03 note indicates that Dr. H refers the patient to Pampa PT to attempt to increase ROM of the wrist. On 3/20/03, Dr. H notes continued restriction of ROM and recommends a continuation of PT for 3 weeks. The 4/14/03 PT note indicates a return of patient to a home exercise program. Improvements in ROM and strength were noted in all categories of measurement from 2/24/03 through 4/8/03. Full ROM was noted on the 6/5/03 note with an ability to perform all ADL's.

## DISPUTED SERVICES

Disputed services include electrical stimulation, therapeutic exercises, therapeutic activities and an office visit from the dates of service 4/1/03 through 4/14/03.

## DECISION

The reviewer disagrees with the previous adverse determination regarding the following services: 97530 on 4/1/03, 4/2/03, 4/4/03, 4/7/03 and 4/8/03; 97110 4/14/03.

The reviewer agrees with the previous adverse determination regarding the following services: 97014 (4/1/03, 4/2/03, 4/4/03 and 4/7/03); 99213 (4/8/03).

## BASIS FOR THE DECISION

The reviewer notes that the above-mentioned conclusions are based upon the following sources: ACOEM Guidelines and the Guidelines of the Council of Physiological Therapeutics and Rehabilitation. The reviewer indicates that there was not sufficient documentation as to the need for a passive therapy (electrical stimulation) at this point in treatment. The reviewer further notes that the usage of an evaluation and management code is not appropriate for a non-physician provider as per the AMA CPT Expert, 2003 Edition. A code of 97001 would be appropriate for a PT evaluation according the same source. The therapeutic activities were medically necessary as they were provided as a direct result of a compensable injury. The patient had a wrist endoscopic CT release and had failed at home care as directed by Dr. H. The treatment did physically and functionally improve the patient's ability to perform activities of daily living, working and be able to reach maximum medical improvement; therefore, per TLC §408.021 these services were medically necessary.

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

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

Sincerely,