

MDR Tracking Number: M5-04-4363-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 February 27, 2004.

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 than one year after the dates of service in dispute therefore dates of service January 29, 2003 through February 24, 2003 in dispute are considered untimely and will not be address in this review.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. The office visits, therapeutic activities, electrical stimulation, ultrasound, and massage from 02-27-03 through 08-25-03 were found medically necessary. 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On September 17, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
04-02-03 05-02-03 05-14-03 05-30-03 06-17-03 07-01-03 07-17-03 08-05-03	99080-73	\$15.00 each date of service	\$0.00	N12	\$15.00	Rule 133.106(f)(1)	The carrier's reason for denial states; "the documentation as submitted does not support the medical necessity of the service." The TWCC 73 is a required report and is not subject to an IRO review, therefore will be reviewed in accordance with rule 133.106(f)(1). Recommend reimbursement of \$120.00.

TOTAL		\$120.00					The requestor is entitled to reimbursement of \$120.00.	

This Findings and Decision is hereby issued this 21st day of January 2005.

Patricia Rodriguez
 Medical Dispute Resolution Officer
 Medical Review Division

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 Order is applicable for dates of service 02-27-03 through 08-25-03 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 21st day of January 2005.

Roy Lewis, Supervisor
 Medical Dispute Resolution
 Medical Review Division

RL/pr
 Enclosure: IRO Decision

October 28, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-4363-01
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 ----- . The patient reported that while at work she injured her left wrist and shoulder when she attempted to restrain a child. The patient was initially treated with conservative chiropractic care and adjunctive therapy modalities. The patient was then treated with a series of steroid injections to the dorsal compartment. On 4/2/03 an MRI of the left wrist revealed a 1.4 ganglion cyst of the left wrist dorsum. On 5/6/03 the patient was again treated with an injection to the left wrist dorsum. The patient continued with conservative care and subsequently underwent a left DeQuervain's release on 9/16/03. Following surgery the patient was treated with postoperative physical therapy. In 11/04 the patient underwent surgical removal of a left wrist ganglion cyst followed by further postoperative physical therapy for 6 weeks.

Requested Services

Office visits, therapeutic activities, electrical stimulation, ultrasound, and massage from 2/27/03 through 8/25/03.

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

Documents Submitted by Requestor:

1. History of Occupational Injury or Illness 2/13/04
2. Office Notes 11/20/02 – 11/26/02, 1/7/03, 1/24/03 – 1/14/04, 1/28/04, 8/6/03 – 8/18/03
3. IME 3/22/03, 5/24/03, 8/25/03
4. Plastic Surgery Evaluation 2/18/03
5. Orthopedic Evaluation 3/24/03
6. MRI report 4/2/03
7. FCE 8/5/02

Documents Submitted by Respondent:

1. Initial Medical Narrative Report (Not Dated)
2. Office Notes 11/27/02 – 2/2/04

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her left wrist on -----. The ----- chiropractor reviewer indicated that the patient underwent several evaluation of the left wrist and was found to have a DeQuervain's Syndrome. The ----- chiropractor reviewer indicated that the patient was treated with six months of therapy and injections and subsequently underwent surgery. The ----- chiropractor reviewer explained that the six months of treatment in question was medically necessary to prevent serious atrophy and deconditioning. The ----- chiropractor reviewer indicated that the type of treatment rendered to this patient was beneficial in relieving pain and promoting healing for 1-2 days at a time. The ----- chiropractor reviewer explained that the treating doctor managed this patient's care the best way possible under the circumstances. The ----- chiropractor reviewer also explained that the treating doctor delivered medically necessary care. The ----- chiropractor reviewer further explained that after surgery and follow up rehabilitation, the patient was found to be at maximum medical improvement within a few months. Therefore, the ----- chiropractor consultant concluded that the office visits, therapeutic activities, electrical stimulation, ultrasound, and massage from 2/27/03 through 8/25/03 were medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department