

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 08-30-04.

The IRO reviewed office visits, therapeutic exercises, neuromuscular re-education, physical performance test and hot/cold packs rendered from 09-12-03 through 05-11-04 that were denied based upon "V".

The IRO determined that the office visits, therapeutic exercises, neuromuscular re-education, performance tests and hot/cold packs from 09-03-03 through 11-03-03 **were** medically necessary. The IRO concluded that the services in dispute for review from 11-07-03 through 05-11-04 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 11-17-04, 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.

Review of CPT codes 99213 and 97112 dates of service 08-27-03 and 03-17-04 and CPT code 97110 date of service 03-17-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement is recommended.

CPT code 99080-73 dates of service 10-02-03, 11-03-03, 12-04-03, 01-05-04 and 04-02-04 denied with denial code "V" (unnecessary medical with peer review). The TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of \$75.00 (\$15.00 X 5 DOS).

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

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 Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), 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 09-12-03 through 04-02-04 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.

Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO Decision

MAXIMUS

Amended 1/18/05
November 12, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-0044-01
TWCC #:
Injured Employee:
Requestor:
Respondent:

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS 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 MAXIMUS for independent review in accordance with this Rule.

MAXIMUS 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 MAXIMUS 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 MAXIMUS 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 MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ---/02. The patient reported that while at work he injured his right wrist and hand. An MRI of the right wrist performed on 1/9/03 was reported to have shown moderated inhomogeneity of the scapholunate ligament suggesting at least a partial degree of tearing in this structure. The patient underwent an EMG/NCV that was reported to have revealed no evidence of peripheral neuropathy. On 6/5/03 the patient underwent a right scapholunate ligament repair. Postoperatively the patient wore a plaster cast until 8/27/03. After the removal of the cast the patient began therapy for finger, elbow and shoulder range of motion and myofascial pain.

Requested Services

Office visits, therapeutic exercises, neuromuscular reeducation, physical performance test, hot/cold packs from 8/27/03 through 5/11/04.

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

Documents Submitted by Requestor:

1. Work and Accident Clinic Daily Note 8/27/03 – 5/25/04
2. Physical Performance Evaluation 10/7/03, 5/17/04

Documents Submitted by Respondent:

1. No documents submitted

Decision

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

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his right wrist and hand on -----. The ----- chiropractor reviewer indicated that the patient was initially treated with 10 months of therapy before undergoing surgery. The ----- chiropractor reviewer noted that the patient's cast was removed and he began a course of therapy. The ----- chiropractor reviewer explained that 6-8 weeks of postoperative rehabilitative care is the standard of care. The ----- chiropractor reviewer also explained that without documented objective or subjective improvement during this time period further treatment would not be medically necessary. The ----- chiropractor reviewer indicated that continued treatment for 9 ½ months without documented improvement is not medically necessary. The ----- chiropractor reviewer explained that the treatment rendered to this patient never led to a relief in this patient's pain or a return to work status. Therefore, the ----- chiropractor consultant concluded that the office visits, therapeutic exercises, neuromuscular reeducation, required medical reports, performance tests and hot/cold packs from 9/3/03 through 11/3/03 were medically necessary to treat this patient's condition. The ----- chiropractor consultant also concluded that the the office visits, therapeutic exercises, neuromuscular reeducation, performance tests and hot/cold packs from 11/7/03 through 5/11/04 were not medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department



TEXAS
WORKERS' COMPENSATION COMMISSION
7551 METRO CENTER DRIVE, SUITE 100, MS-48, AUSTIN, TEXAS 78744-7551
(512) 804-4800

MEMORANDUM

DATE: / / **2005**

TO: **Austin Commission Representative, Box 19**

CARRIER: **American Home Assurance Company**

FROM: **Medical Review Division**

RE: **NOTICE of Independent Review Organization and Medical Dispute Resolution
DECISION & ORDER**

This memorandum shall serve as your notice to present yourself to the Mail Room Service Counter:

(X) An IRO and MDR Decision & Order.

The above referenced document has been issued in a medical dispute case review pertaining to the following claimant and insurance carrier:

IDENTIFIER

MDR TRACKING #: M5-05-0044-01
TWCC FILE #: 03282384
CLAIMANT: Bill E. Johnson
DOI: 10-18-2002
SSN: 461-39-2874
SERVICE FROM: 08-27-03
SERVICE TO: 05-11-04

I, the undersigned Representative of the above referenced insurance carrier, do hereby acknowledge receipt of the IRO and MDR Decision & Order applicable to a medical dispute resolution request solicited by the requestor.

Receipt of this Decision & Order is hereby acknowledged this _____ day of _____ 2005.

Signature of Commission Representative: _____

Printed Name of Commission Representative: _____