

MDR Tracking Number: M5-05-0392-01

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. The dispute was received on 9/29/04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO reviewed office visits, chiropractic manipulative treatment extra spinal, electrical stimulation unattended, ultrasound, therapeutic procedure massage, whirlpool, and therapeutic procedure range of motion. The IRO agrees with the previous determination that these services were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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

On 11/02/03, 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:

No EOB: Neither party in the dispute submitted EOBs for the disputed services identified below. Since the Carrier did not raise the issue that they had not had the opportunity to audit these bills and did not submit copies of EOBs the Medical Review Division will review these services per the *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
9/29/03 10/08/03	99213	\$65.21	\$-0-	Y-MU-N	\$65.21	Rule 134.202	The Carrier denied reimbursement as "Physical Medicine and Rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day." The Texas Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries LCD states: "When both a modality/procedure and an evaluation service are billed, the evaluation may be reimbursed if the medical necessity for the evaluation is clearly documented. Standard medical practice may be one or two visits in addition to physical therapy treatments. Reimbursement beyond this standard utilization requires documentation supporting the medical necessity for the

							office visit." No additional documentation was submitted to support these services. No additional reimbursement is recommended.
12/17/03 12/22/03	99213 99214	\$101.74 \$65.21	\$-0-	No EOB	\$101.74 \$65.21	Rule 133.307(f)(3)	The Requestor did not submit convincing evidence to support the Carrier was in receipt of the Provider's request for EOBs. Reimbursement is not recommended.
TOTAL							The requestor is not entitled to reimbursement.

Based upon the review of the disputed healthcare services within this request, the Division has determined the requestor **is not** entitled to reimbursement for dates of service from 9/29/03 to 6/18/04 and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 25<sup>th</sup> day of January 2005.

Pat DeVries  
Medical Dispute Resolution Officer  
Medical Review Division

PRD/prd

Enclosure: IRO Decision

December 17, 2004

Texas Workers Compensation Commission  
MS48  
7551 Metro Center Drive, Suite 100  
Austin, Texas 78744-1609

#### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-05-0392-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Jack Barnett, D.C. & Airline Chiropractic Clinic**  
**Respondent: Texas Mutual Ins. Co.**  
**MAXIMUS Case #: TW04-0484**

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 23 year-old male who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work he injured his right hand and small finger when he got his hand caught in an engraver. Plain films of the right hand performed on 10/13/03 revealed no acute radiographic abnormality of the right hand. An MRI of the right hand performed on 10/16/03 revealed flexion contracture of the fifth ray, right hand, effusion of the PIP, fifth ray right hand, r/o probable partial tear, flexor retinaculum, without evidence of a complete tear to the common flexor tendon, and inner osseous contusion, distal phalanx, fifth ray. The diagnoses for this patient have included laceration of the right fifth digit, hand sprain/strain, right wrist internal derangement, shoulder sprain/strain. On 12/3/03 the patient underwent an extensive contracture release, contracture release of PIP joint, modified capsulotomy of PIP joint, contracture release of DIP joint, capsulotomy of DIP joint, excision of massive fibrotic tissue, tenolysis, flexor profundus tendon, tenolysis flexor sublimis tendon, neurolysis of digital nerve, radial side with microvascular technique, neurolysis of digital nerve, ulnar side, with microvascular technique, reconstruction of right little finger with multiple Z-plasties, and reconstruction of right little finger with full thickness graft. The patient underwent amputation of the right little finger on 4/23/04. Further treatment for this patient's condition has included whirlpool, interferential treatment, ultrasound, moist heat, therapeutic exercises, and massage.

### Requested Services

Office visit, chiropractic manipulative treatment extra spinal, electrical stimulation unattended, ultrasound, therapeutic procedure massage, whirlpool, therapeutic procedure range of motion, and office visit 99211 from 9/29/03 through 6/18/04.

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

#### *Documents Submitted by Requestor:*

1. Plain Film Report 10/13/03
2. Letter to TWCC from Treating Doctor 9/2/03
3. Office notes and treatment records 9/3/03 – 7/21/04
4. Operative Note 12/3/03 and 4/23/04

*Documents Submitted by Respondent:*

1. No documents submitted.

Decision

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

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a 23 year-old male who sustained a work related injury to his right hand and small finger on \_\_\_\_\_. The MAXIMUS chiropractor reviewer also noted that the diagnoses for this patient included laceration of the right fifth digit, hand sprain/strain, right wrist internal derangement, shoulder sprain/strain. The MAXIMUS chiropractor reviewer further noted that the patient underwent extensive surgery to the right hand on 12/3/03 and subsequently underwent amputation of the right little finger followed by further therapy. The MAXIMUS chiropractor reviewer explained that the periodic summaries provided in the case file do not document objective improvement in this patient's condition with the treatment rendered. The MAXIMUS chiropractor reviewer also explained that without documented subjective and objective improvement, continued treatment is not medically necessary.

Therefore, the MAXIMUS chiropractor consultant concluded that the office visit, chiropractic manipulative treatment extra spinal, electrical stimulation unattended, ultrasound, therapeutic procedure massage, whirlpool, therapeutic procedure range of motion, and office visit 99211 from 9/29/03 through 6/18/04 were not medically necessary to treat this patient's condition.

Sincerely,

**MAXIMUS**

Elizabeth McDonald  
State Appeals Department