

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 October 25, 2004.

The IRO reviewed CPT Codes 99212, 97140, and 97110 that were denied based upon "U" and "V".

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(q)(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.

CPT Codes 99212, 97140 and 97110 for dates of service 11/11/03 through 01/22/04 **were** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for CPT Codes 99212, 97140, and 97110.

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.

On November 12, 2005, 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 99212 for date of service 11/18/03. Neither party submitted an EOB; therefore, this CPT Code will be review in accordance with Rule 134.202, Medical Fee Guideline and the Medicare Fee Schedule. Per 134.202(b) and the Medicare Fee Schedule, clinical notes support services were rendered as billed. Reimbursement in the amount of \$47.23 (\$37.78 x 125%) is recommended.

This Decision is applicable for dates of service 11/11/03 through 01/22/04 in this dispute.

This Decision is hereby issued this 21st day of January 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

NOTICE OF INDEPENDENT REVIEW DECISION

December 21,2004

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-05-0618-01
IRO Certificate #: IRO 4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 33 year-old female injured her bilateral wrist on ___ after repetitive lifting of heavy trays of mail. She has been treated with medication, therapy and surgery. Her diagnosis is Kienboch's disease.

Requested Service(s)

Office visits, manual therapy techniques, therapeutic exercise for dates of service 11/11/03 through 01/22/04

Decision

It is determined that there is medical necessity for the office visits, manual therapy techniques, and therapeutic exercise for dates of service 11/11/03 through 01/22/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient sustained a repetitive motion injury to her left wrist on ____. This injury resulted in avascular necrosis of the lunate (Kienboch's disease). She was evaluated and an aggressive treatment program was performed. She had initially responded favorably to treatment but experienced an exacerbation that led to surgical intervention. After surgery she was placed in a hard cast. The evaluation after removal of the cast revealed severely restricted range of motion and inflammation with strength loss. An aggressive post-operative rehabilitation program was begun.

This case was much more complicated than an uncomplicated carpal tunnel release surgery or wrist surgery and therefore required a more intensive and prolonged post-operative rehabilitation program. There is sufficient documentation to clinically justify the services that were performed on each of the denied dates of service. Her condition responded to treatment and she was able to regain a pain free status and return to full duty work.

In conclusion, it was medically necessary for this patient to receive the office visits, manual therapy techniques, and therapeutic exercise for dates of service 11/11/03 through 01/22/04 to treat this patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-0618-01

Information Submitted by Requestor:

- Requestor Position
- Peer Review
- Progress Notes
- Diagnostic Tests
- Consults
- Work Hardening Program
- Impairment Rating
- Maximum Medical Improvement
- Claims

Information Submitted by Respondent:

- Peer Review
- Claims