MDR Tracking Number: M5-03-0907-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 11-25-02.

The IRO reviewed chiropractic treatment rendered from 6-10-02 to 7-25-02 that were denied based upon "U".

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.

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 June 13, 2003, 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$ (Maximum Allowable Reimbursement)	Reference	Rationale
6-10-02	99213	$48.00	$0.00	No EOB	$48.00	Physical Medicine GR (I)(A)(8)	EOB indicates that on this date 99204 was also billed. 6-10-02 report indicates physical therapist evaluated claimant. Reimbursement of $48.00 is recommended.
6-13-02 6-20-02	97014	$15.00	$0.00	F	$15.00	CPT code description	SOAP note supports billed service. Reimbursement is recommended of 2 dates X $15.00 = $30.00.
TOTAL		$78.00					The requestor is entitled to reimbursement of **$78.00.**

This Decision is hereby issued this 4th day of September 2003.

Elizabeth Pickle
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 Decision is applicable for dates of service 6-10-02 through 7-25-02 in this dispute.

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.

This Order is hereby issued this 4th day of September 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

June 5, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5 03 0907 01
IRO #: 5251

___ 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 ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an 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 Doctor of Chiropractic. The ___ 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 ___ 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

This patient suffered from multiple fractures of digits 1 through 4 on his right hand after an injury on the job on ___. He underwent debridement of digits 1-4, a repair of the flexor tendon of the right thumb, open reduction internal fixation of the distal phalanx of the thumb as well as the PIP of the 3rd and 4th digits. There were also complex lacerations of the right index finger and right thumb. The patient was referred to ___ on June 10, 2002 for the purpose of rehabilitation and therapy to the right hand after the traumatic incident. He initially presented with severe pain in the right hand, as would be expected and weakness of that extremity. He was initially treated with passive modalities and later progressed into active treatment. This treatment continued until July 26, 2002, when the patient was referred back to his treating doctor for further evaluation.

DISPUTED SERVICES

The carrier has denied the medical necessity of electrical stimulation, ultrasound, therapeutic exercise, MP office outpatient visits and PT whirlpool as medically unnecessary. Dates reviewed include June 13, 19, 20, 24, 25, 26, 27, and 28th as well as July 2, 3, 8, 9, 10, 11, 12, 15, 16 and 17th.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

There is no dispute that this patient was severely injured on the right hand and that it required a significant surgical intervention. This was clearly no minor sprain or cut, but rather an injury that could have caused this patient the future use of his hand. The records indicate that conservative treatment was utilized by the PT involved in the case and that it was appropriately utilized in a progressive manner in order to get the patient back to work in the most efficient manner possible. Also note that the care is much more efficient than most cases this reviewer has seen and the patient did respond to the care. It is worth reviewing the documentation to find that the patient appropriately responded to the care and that no attempts were made to “force” the injury to respond to overly

aggressive therapy. As a result, all of the treatment rendered would be considered reasonable and necessary for the treatment of this patient's injury.

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

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

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,