

MDR Tracking Number: M5-03-1369-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 1-31-03.

The IRO reviewed chiropractic treatment rendered from 3-5-02 through 5-30-02 that were denied based upon "V".

The insurance carrier also utilized EOB denial code "T" to deny above services. HB-2600 abolished the treatment guidelines; therefore, the insurance carrier incorrectly used EOB denial "T".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the 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 April 9, 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:

Services that were denied without an EOB will be reviewed in accordance with *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS\$ (Maximum Allowable Reimbursement)	Reference	Rationale
3-12-02 3-13-02	97110 (X3)	\$105.00	\$0.00	No EOB	\$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	SOAP note does not support severity of injury to require one to one supervised therapy per MFG. Also, the requestor did not document one to one supervised treatment per MFG; therefore, no reimbursement is recommended.

3-12-02 3-13-02	97122	\$35.00	\$0.00	No EOB	\$35.00	CPT Code Descriptor	SOAP notes supports billed service per MFG, reimbursement is recommended of 2 dates X \$35.00 = \$70.00.
3-12-02 3-13-02 3-25-02 4-1-02 4-8-02 5-23-02	99213	\$48.00	\$0.00	No EOB	\$48.00	Evaluation & Management GR (IV)	SOAP notes supports billed service per MFG, reimbursement is recommended of 6 dates X \$48.00 = \$288.00.
3-12-02 3-13-02	97265	\$43.00	\$0.00	No EOB	\$43.00	CPT Code Descriptor	SOAP notes supports billed service per MFG, reimbursement is recommended of 2 dates X \$43.00 = \$86.00.
TOTAL							The requestor is entitled to reimbursement of \$444.00.

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 3-5-02 through 5-30-02 in this dispute.

This Decision and Order is hereby issued this 12th day of November 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

April 7, 2003

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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

The patient was injured on his job when his finger was caught in a machine, causing a fracture to the 4th metacarpal of the left hand. He was initially treated by ___ and later changes his treating doctor to ___. Treatment rendered by the treating doctor consisted of extensive care to include traction, joint mobilization myofascial release, active rehabilitation and other extensive care. MRI was performed by the treating clinic and demonstrated no particular abnormality, with the exception of a small bone fragment near the site of the fracture (March 15, 2002). RME doctor ___ found the patient to be at MMI in June of 2002. However, no TWCC 69 form is found in the documentation.

REQUESTED SERVICE

The carrier on this case has denied the medical necessity of office visits, special reports, X-rays, MRI, joint mobilization, therapeutic procedures, physical performance tests, myofascial release, traction, range of motion testing and data analysis as medically unnecessary.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The care that was rendered on this case was clearly excessive and unnecessary, especially considering the diagnosis. While a metacarpal fracture is certainly something that can be painful, we must also be mindful of the fact that such injuries are best treated with rest and then a light home exercise in most cases. There is nothing in this file that indicates that this is a complicated case. In fact, the MRI indicates that there was no abnormality of significance in this patient's hand. While the MRI did probably accurately view the site of the fracture, the test itself was not a reasonable test for such an injury as it would be best described as overkill. I see no reason for mechanical traction, which would be difficult to perform on an acute fracture (if one so existed) and I see no benefit for a healed fracture with a traction of a joint space. Joint mobilization also is unnecessary in this case, as the fracture is not known to impede the motion of a joint. Overall, this case was handled with greatly excessive care and there is no indication that the case was helpful in returning this patient to the workplace or achieving MMI.

___ 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 ___, Inc, dba ___, 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 by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,