MDR Tracking Number: M5-03-1425-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 Medical Review Division has reviewed the IRO decision. The requestor did not prevail in the IRO decision. 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 the only issue** to be resolved. The codes 97110 and 97265 from 3-25-02 through 4-15-02 were found to be medically necessary. The code 99213 from 3-25-02 through 4-15-02 was found to be medically necessary at once per month only. The codes 97112, 97122, 97250, 99070, E0745, and E1399 from 3-25-02 through 6-14-02 were not found to be medically necessary. All services rendered from 4-17-02 through 6-14-02 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these services charges.

The above Findings and Decision are hereby issued this 12th day of May 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 Order is applicable to dates of service 3-25-02 through 6-14-02 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 12th day of May 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dzt

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 9, 2003

RE: MDR Tracking #: M5-03-1425-01
IRO Certificate #: 5242

___ 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___ 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 proposed 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 Chiropractic physician reviewer. The Chiropractic physician reviewer 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 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

It appears the claimant was the driver of a school bus on ___ when she began to experience left wrist pain while making a right turn. It appears her left wrist took on an awkward position and this caused a popping and tearing sound in her left wrist. She underwent an initial 8 weeks of conservative care under the direction of a chiropractor, and was returned to work; however, her condition digressed and she was sent for further diagnostic work up. A designated doctor exam of 2/1/02 revealed the claimant was not at maximum medical improvement. There were some delays in treatment or referrals due to some compensability issues. The claimant eventually won her case at a BRC and contested case hearing. The claimant underwent electrodiagnostic studies with the doctor and this revealed moderate to severe carpal tunnel syndrome on the left. The claimant was rather apprehensive about surgery and wanted to exhaust all reasonable avenues of conservative intervention. It appears some work hardening was done, but the claimant continued to digress and eventually underwent surgery on 3/1/02. It should be noted that the 3/1/02 surgery consisted of a deQuervain's release or a tenosynovitis release surgery. An initial post operative physical therapy program was begun on or about 3/25/02 under the direction of the doctor. It should be noted the electrodiagnostic work up done by the doctor also revealed a C6/7 radiculopathy from the cervical nerve roots on the left. This would not be considered related to the injury. An independent medical exam was done on 10/3/01 and the claimant was felt to have 0% impairment rating; however, this report is not provided in the documentation for review. It appears the insurance carrier did compensate for some work conditioning which was done after the post operative rehabilitation program that was performed by the doctor. The claimant was released to maximum medical improvement status by the doctor in July 2002 with 6% whole person impairment rating. A fairly voluminous amount of medical records from 3/25/02 onward were reviewed that included daily notes and post operative rehabilitation notes through 6/14/02. The codes which were billed throughout the 3/25/02 through 6/14/02 range of services included a 99070 code for a tube of Biofreeze, 97250 code for group therapeutic procedures, a 97265 code for manual therapy, a 99213 office visit code, a 97110 therapeutic exercise code, a 97112 neuromuscular re-education code and a 97122 code for gait training. There were also some durable medical equipment codes in the form of EO745 that was billed twice and an E1399 that was billed once that was related to some durable medical equipment which included some electrical stimulation pads as well as the neuromuscular stimulator unit.

Requested Service(s)

The medical necessity of chiropractic services from 3/25/02 through 6/14/02.

Decision

I agree with the insurance carrier and find that all services rendered from 4/17/02 through 6/14/02 were not reasonable or medically necessary. I agree with the insurance carrier and find that codes 97112, 97122, 97250, 99070, EO745, and E1399 that were rendered from 3/25/02 through 6/14/02 were not reasonable or medically necessary. I agree with the insurance carrier and find that office visits that were billed under 99213 beyond a frequency of once per week from 3/25/02 through 4/15/02 were not reasonable or medically necessary. I disagree with the insurance carrier and find that codes 97265 and 97110 were reasonable and medically necessary from 3/25/02 through 4/15/02 only and that the 99213 code that was billed from 3/25/02 through 4/15/02 was reasonable and medically necessary at only once per week.

Rationale/Basis for Decision

The clinical documentation from the doctor was carefully reviewed; however, the slow steady improvements noted on the periodic re-evaluations were not significant enough to warrant the voluminous and quite extensive treatment, much of which was simply not reasonable or medically necessary for treatment of the diagnosis. Certainly some post operative rehabilitation was reasonable and medically necessary; however, on most or all of the dates of service the carrier was billed for a tube of Biofreeze, neuromuscular re-education and daily or 3 times per week office visits as well as medically unnecessary durable medical equipment. To bill the insurance carrier for a tube of Biofreeze on every visit, that occurred 40 times, is not cost effective or reasonable or medically necessary. This would mean that essentially the claimant was dispensed $650 worth of Biofreeze and this is simply not cost effective and is certainly not reasonable or medically necessary. Neuromuscular re-education, which was the 97112 code, is typically used for rehabilitation of central nervous system disorders or spinal cord disorders. I fail to see how neuromuscular re-education would be needed for a wrist tendon problem. There was no need for myofascial release following a tendon release surgery. There was no need for an office visit charge on every physical therapy visit. Office visits once per week during a routine post operative physical therapy program would be more than sufficient. This would allow for a proper sequence of office visits that would allow for sufficient monitoring of the claimant. Joint mobilization was not reasonable or medically necessary and is not standard protocol for post operative rehabilitation of a deQuervain's or tenosynovitis release surgery. In a situation in which functional active restoration is the primary goal, there is no need for a TENS or portable neuromuscular stimulator unit for a tendon release surgery post operatively. The documentation provided for review, which consists of daily rehabilitation notes, only documents the active portion of the rehabilitation that is consistent with the 97265 and 97110 codes as billed. Also, it is important to realize that the improvements noted were improvements that were consistent with increased sensation in the C7/8 dermatome levels as well as improvements in reflexes of the upper extremities. These increases and improvements have nothing to do with the compensable injury and since there were improvements in these areas, then the improvements that were listed in the related areas of range of motion of the wrist should be questioned. It was my opinion that the improvements were just a little bit too convenient to be believed. Also, please consider that according to the highly evidence based Official Disability Guidelines 2003 issue, post operative rehabilitation of tenosynovitis release surgery consists of 14 visits with transition into a home based exercise program. This claimant underwent 40 visits and then she underwent a 3 week work conditioning protocol. This would be considered excessive and not in line with the recognized evidence based Official Disability Guidelines. Also please consider that following a release surgery such as this, a return to work usually occurs at anywhere from 14-42 days post surgery. Although some physician directed post operative rehabilitation was of course reasonable and medically necessary, the documentation revealed the claimant was performing finger webbing exercises, hand strengthening exercises and range of motion exercises specifically at the left wrist. Once a sufficient physician directed physical therapy program such as this was performed, then the claimant should have been well versed enough by the 14th visit to continue on her own and resume some sort of employment. This claimant was only required to drive a bus for a few hours per day and the Official Disability

Guidelines recommend that she should have been able to drive a heavy duty vehicle at up to 3 hours per day within a short amount of time following her surgery. This study was based on hundreds of similar injuries and similar surgeries as this claimant underwent. The 4/15/02 date, which was in my opinion the end treatment date in this case, was 45 days post operatively and according to the Official Disability Guidelines, the average return to work is anywhere from 14-42 days. I believe this is more than reasonable and gives the maximum benefit of the doubt to the claimant. Also please consider that the claimant participated in a 3 week work conditioning program that went beyond the 40 visits of post operative physical therapy that were already rendered. It is my opinion that the 14 visits which occurred from 3/25/02 through 4/15/02 combined with the 3 weeks of work conditioning were more than sufficient post operative rehabilitation for this uneventful tenosynovitis release surgery especially when considering that many of the exercises rendered as documented could have been done at home once she was properly instructed. This instruction could have taken place within a few visits and 14 visits which had been recommended are more than sufficient to serve this purpose. To sum up, the only reasonable and medically necessary services occurred from 3/25/02 through 4/15/02 and the only reasonable and medically necessary services as billed during the 3/25/02 through 4/15/02 time period were the office visits at the 99213 code level of once per week only, as well as the codes 97265 and 97110 billed from 3/25/02 through 4/15/02. Any and all other codes that were billed, except for those mentioned above, would not be considered reasonable or medically necessary and would not be supported by the documentation provided for review. Again, the Official Disability Guidelines recommend 14 post operative visits, not 40 as occurred here. It was obvious this claimant would have been well versed after the 14th visit to continue on her own especially with respect to range of motion exercises, finger webbing and Eggsercizer. It is important not to forget that this was a wrist problem and the claimant could have used her non-involved hand to provide active resistive exercises and she could have continued on her own via finger putty, finger webbing, and self strengthening exercises on her own.