THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION:

SOAH DOCKET NO. 453-03-4035.M5

MDR Tracking Number: M5-03-1609-01

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 and determined that the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare; therefore, 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 therapeutic procedure from 5-28-02 through 6-19-02 and office visits billed once per week from 5-28-02 through 6-19-02 were found to be medically necessary.

The myofascial release from 5-28-02 through 7-23-02, range of motion and strength testing from 5-28-02 through 6-27-02, physical performance evaluation on 7-9-02, CPT testing on 5-30-02, MRI on 6-14-02, neuromuscular stimulator on 7-25-02, therapeutic procedures from 6-20-02 through 8-26-02, and office visits on 5-29-02, 5-30-02, and 6-20-02 through 10-14-02 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these services charges.

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 5-28-02 through 10-14-02 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 10th day of June 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

NOTICE OF INDEPENDENT REVIEW DECISION - REVISION

Date: June 10, 2003

RE: MDR Tracking #: M5-03-1609-01
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 chiropractor physician reviewer. The chiropractor 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 suffered a distal radius fracture, when she fell on her left arm while in the normal course and scope of her employment as a housekeeper, on ___. It appears that she did have the arm casted. However, she ended up changing treating physicians to. __, on or about 05/24/02. Her first chiropractic visit reportedly occurred on 05/24/02. __ began a rehabilitation program to include myofascial release, chiropractic management and therapeutic activities. Claimant also had alleged decreased sensory findings in the C6, 7 and 8 levels in the left upper extremity. __ did respond to a peer review which was done that basically stated chiropractic care was not reasonable and medically necessary. This letter of 10/01/02 was reviewed. Multiple and voluminous amounts of chiropractic daily notes, including range of motion and strength testing findings, were reviewed. The left wrist MRI report was reviewed. Several follow ups from __ were reviewed. It was felt the claimant may have carpal tunnel syndrome. However, she had electrodiagnostic evidence of carpal tunnel syndrome noted to be worse on the non-involved right side then the left side. Range of motion and strength testing on or about 05/28/02, 06/12/02, 06/25/02, 07/09/02 and 08/07/02 were reviewed. Claimant underwent current perception threshold testing through the chiropractic office on or about 05/30/02. Claimant underwent a physical performance evaluation on 07/09/02 that really did not meet standardization protocols for these types of examinations.

Requested Service(s)

Medical necessity of the outpatient services including office visits, physical therapy sessions, muscle testing, range of motion testing, DME, MRI and neurological diagnostic procedures which were rendered from 05/28/02 through 10/14/02.

Decision

I agree with the insurance carrier that all of the myofascial release which was performed from 05/28/02 through 10/14/02 would not be considered reasonable and medically necessary. I agree with the insurance carrier that all range of motion and strength testing; including codes 95851 and 97750 were not reasonable and medically necessary. I agree with the insurance carrier that the CPT or current perception threshold testing billed at 95999-MT on 05/30/02 was not reasonable and medically necessary. I agree with the insurance carrier that the MRI of the left wrist billed on 06/14/02 was not reasonable and medically necessary. I agree with the insurance carrier that the neuromuscular stimulator unit, which was prescribed on 07/25/02, would not be considered reasonable and medically necessary. I agree with the insurance carrier that office visits billed on every visit from 05/28/02 through 10/14/02 would not be considered reasonable and medically necessary. I disagree with the insurance carrier and find that the codes billed at the 97110 code through 06/19/02 from 05/28/02 would be considered reasonable and medically necessary. I disagree with the insurance carrier and find that office visits, which were billed at 99213 and billed one time per week, would be considered reasonable and medically necessary through 06/19/02 only.

Rationale/Basis for Decision

The myofascial release would not be considered an efficacious or reasonable and medically necessary procedure for fracture of a distal radius. The Occupational Medicine Practice Guidelines do not recommend myofascial release for this type of injury and myofascial release would not be considered to be appropriate for a fracture, especially over seven (7) weeks post injury.

As far as the range of motion and strength testing billed at 95851 and 97750, there are more appropriate cost-effective ways to measure range of motion and strength. This could have been done through an office visit on the first visit and then repeated once per month by using a goniometer and through the use of routine grip strength testing via a Dynamometer. The claimant could have also had her muscles or strength tested at the wrist via routine manual muscle testing done by the chiropractor as part of a routine office visit.

As far as the CPT testing which was billed at 95999-MP on 05/30/02 this testing has not been shown to be reliable and is mainly a subjective test. There was no clinical evidence other than subjective evidence that the claimant had carpel tunnel syndrome and the lack of clinical evidence of carpel tunnel syndrome would not want diagnostic testing for the carpal tunnel syndrome.

As far as the MRI of the left wrist which was billed on 06/14/02 again, I feel there was no clinical evidence to suggest that this was more than an uncomplicated distal radius fracture. The alleged carpal tunnel syndrome signs and symptoms were global in the upper extremity and mainly subjective. There was no clinical evidence in the chiropractic documentation that this claimant had specific signs and symptoms associated with carpal tunnel syndrome to warrant the MRI. There were no other clinical findings to suggest that the claimant was having any other complications related to her wrist, hand or arm that would warrant the MRI. Again, this was a routine distal radius fracture that usually heals within about six (6) weeks. There was no information or documentation to suggest that this was a complicated case and the extensive amount of care that was rendered was not reasonable and medically necessary by the nature of the injury.

As far as the neuromuscular stimulator unit that was prescribed and billed on 07/25/02, a neuromuscular stimulator unit would not be considered reasonable and medically necessary for a distal radius fracture, especially two (2) months after the initiation of chiropractic physical therapy and nearly sixteen (16) weeks post injury.

As far as the use of the 99213 office visit on every visit, this would not be considered reasonable and medically necessary, unless, the chiropractor was the one who was actually performing the actual physical therapy. Routine office visits are not indicated on every physical therapy visit. However, physician directed office visits for coordination of care and overall patient management at once per week from 05/28/02 through 06/19/02 would be considered reasonable and medically necessary.

As far as the 97110 code that was billed from 05/28/02 through 06/19/02, this would be considered reasonable and medically necessary according to the nature of the injury. The claimant reportedly had just been removed from her cast and some stiffness and pain would be normal. I do feel that she should be entitled to about sixteen (16) visits of active physical therapy in accordance with the highly evidence based Official Disability Guidelines 2003 issue which recommends sixteen (16) physical therapy visits over an eight week period. The claimant underwent her sixteenth visit on or about 06/19/02 and given the fact that she had undergone sixteen (16) visits of active care, she should have been transitioned to a home based exercise program because she should have been well versed on the physical therapy such that she could continue at home. Also, please consider that the claimant's range of motion and overall strength actually peaked on or about 06/12/02 and did not appreciably improve beyond this date except for one tiny spike, at which point the claimant's flexion strength increased quite inexplicably from 06/13/02 through 06/27/02. In the context of the documentation this increase in wrist flexion strength would be considered incidental and irrelevant because the rest of the documentation does not show steady improvement from 06/19/02 onward.

To sum up, the only medically necessary services occurred from 05/28/02 through 06/19/02 in the form of codes 97110 and once per week office visits at 99213. All other services would not be considered reasonable and medically necessary. Any and all services beyond 06/19/02 would not be considered reasonable and medically necessary for the reasons already listed above. As far as the physical performance evaluation which was done on 07/09/02, this test lacked standardization and really did not provide sufficient information and would not be considered

sufficient to gauge return to work issues and overall function of the claimant. The physical performance evaluation that was done, mainly dealt with walking with trays and sorting activities, which would really have nothing to do with this claimant's housekeeping job. The claimant underwent some 4-Standing Work Tolerance Performance Ratings. These were not even dated on some occasions. The claimant's Oswestry Questionnaire was often incomplete. The overall outcome assessments were lacking and the proper functional capacity evaluation was not done.

Please also consider that the average cost for a distal radius and/or ulna fracture out of over 53,000 cases studied, came out to be $10,305.00, yet the chiropractor, all by himself billed $9,112.00. This would indicate that the services rendered exceeded the average cost out of numerous other cases studied. It was obvious that the amount of treatment exceeded the Official Disability Guidelines 2003 issue as mentioned above. Again, some active physical therapy was reasonable and medically necessary because the claimant had just come out of a cast and the Official Disability Guidelines do recommend up to sixteen (16) visits of physical therapy for this type of injury.