

MDR Tracking Number: M5-03-2992-01

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 07-17-03.

The IRO reviewed work hardening, office visits, conductive paste gel, and wrist hand finger orthoses rendered from 01-22-03 through 03-13-03 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 for work hardening, office visits, conductive paste gel, and wrist hand finger orthoses. Therefore, upon receipt of this Order and in accordance with §133.308(r)(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.

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 09-10-03, 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	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
11-25-02	99213	\$48.00	\$24.00	No EOB	\$48.00	MFG, E & M GR(IV)(C)(2)	Relevant information was not submitted to support delivery of service for date of service.
12-16-02	99213	\$48.00	0.00		\$48.00	MFG, E & M GR(IV)(C)(2)	Soap notes support delivery of service. Recommended Reimbursement \$48.00

01-13-03	99213	\$48.00	0.00		\$48.00	MFG, E & MGR (IV)(C)(2)	Soap notes support delivery of service. Recommended Reimbursement \$48.00
01-21-03	97545-WH (2 hours)	\$128.00	\$64.00	H	\$64.00 per hour	MFG, MGR (II)(C) & (E)	Per rule 133.303 information regarding results of onsite audit were not submitted therefore Recommended Reimbursement \$64.00
	97546-WH (6 hours)	\$384.00	\$192.00	H			Per rule 133.303 information regarding results of onsite audit were not submitted therefore Recommended Reimbursement \$192.00
01-23-03	97545-WH (2 hours)	\$128.00	0.00	No EOB		MFG, MGR (II)(C) & (E)	Soap notes support delivery of service. Recommended Reimbursement \$128.00 (\$64.00 for 2 hours)
	97546-WH (2 hours)	\$128.00	0.00				Soap notes support delivery of service. Recommended Reimbursement \$128.00 (\$64.00 for 2 hours)
01-29-03	97545-WH (2 hours)	\$128.00	0.00			MFG, MGR (II)(C) & (E)	Soap notes support delivery of service. Recommended Reimbursement \$128.00 (\$64.00 for 2 hours)
	97546-WH (6 hours)	\$384.00	0.00				Soap notes support delivery of service. Recommended Reimbursement \$384.00 (\$64.00 for 6 hours)
01-30-03	97545-WH (2 hours)	\$128.00	0.00			MFG, MGR (II)(C) & (E)	Soap notes support delivery of service. Recommended Reimbursement \$128.00 (\$64.00 for 2 hours)
	97546-WH (4 hours)	\$256.00	0.00				Soap notes support delivery of service. Recommended Reimbursement \$256.00 (\$64.00 for 4 hours)
TOTAL		\$1808.00					The requestor is entitled to reimbursement of \$1504.

This Decision is hereby issued this 28<sup>th</sup> day of April 2004.

Georgina Rodriguez  
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 12-16-02 through 03-13-03 in this dispute.

This Order is hereby issued this 28<sup>th</sup> day of April 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

September 5, 2003  
**Amended April 1, 2004**

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

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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.

The independent review was performed by a matched peer with the treating doctor. 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

\_\_\_ was injured on \_\_\_. She went to the ER and was diagnosed with a fractured distal radius and was kept off work for two weeks, then returned to work. She had pain and was taken off work for two more weeks. She then went to see \_\_\_, who ordered x-rays, MRI and other diagnostic testing that showed the patient's sensory deficits which were due to bilateral carpal tunnel and possible cubital tunnel.

The patient also saw \_\_\_ who requested surgical procedure for this patient. The request was denied and resubmitted on 11/13/02. Since surgery was being denied, \_\_\_ continued with conservative measures, placing the patient in a work hardening program. The patient evidently had surgery in June or July of 2003 because there is a note from \_\_\_ where he was taking out the sutures, but there was no note in particular that states when the surgery was done. The carrier had approved an extension of the work hardening program for an additional two weeks.

#### DISPUTED SERVICES

Under dispute is the medical necessity of a work hardening program from 1/22/03 through 3/13/03; office visits on 1/31/03 & 2/13/03, wrist-hand-finger orthoses and conductive paste gel.

#### DECISION

The reviewer disagrees with the prior adverse determination.

#### BASIS FOR THE DECISION

\_\_\_ was injured on the job, fracturing her left distal radius, leaving her with carpal tunnel compromise. She was treated conservatively and objective data confirmed the severity of her problems. FCE testing showed that she was not able to perform her regular work duties and she was put in a work hardening program to help return her to her job and minimize the risk of re-injury. In light of the fact that surgery had been recommended and being denied, it was in the patient's best interest to attempt to ready her for her regular job duties. The work hardening program was reasonable and necessary due to the objective findings and in light of the other facts stated above.

\_\_\_ 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,