MDR Tracking Number: M5-03-3215-01

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 8-7-03.

The IRO reviewed office visits, hot/cold packs, therapeutic activities, electric stimulation and supplies rendered from 8-7-02 through 11-14-02 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(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** 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 October 28, 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
9-4-02 9-17-02 10-23-02	97010	$12.65	$0.00 $9.90 $9.90	F, C	$11.00	CPT Code description	Patient care sheet indicates hot/cold packs were rendered. Dates of service 9-17 and 10-23 were paid in accordance with fee guideline and contract; therefore, reimbursement per MFG of X $11.00 for 9-4-02 is recommended.
9-4-02	97110 (4)	$161.00	$0.00	F, C	$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	Patient care sheet does not support exclusive one to one supervised therapy per MFG. No reimbursement is recommended.

9-17-01	99361	$60.95	$47.70	F, C	$53.00	CPT Code description	EOBs indicate that services were paid based upon fee guideline and a contract; therefore, further assistance from MDR is not necessary.
9-17-02 10-23-02	97110 (3)	$120.75	$94.50 $94.50	F, C	$35.00 / 15 min	Medicine GR (I)(A)(9)(b)	
TOTAL							The requestor is entitled to reimbursement of **$11.00.**

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 8-1-02 through 11-14-02 in this dispute.

This Decision is hereby issued this 18th day of November 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

November 17, 2003

Re: MDR #: M5-03-3215-01
IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Orthopedics.

Clinical History:

This male claimant suffered a work-related injury on ___, resulting in scapholunate instability. He underwent surgery on 07/17/01 for repair of scapholunate ligament with dorsal capsulodesis with a sling anchor from the triquetrium over to the scaphoid. A surgical procedure for excision of deep buried hardware, right wrist, consisting of four K-wires was done on 11/16/01. There was a question of infection, and on 04/04/02 he had to be re-operated on to re-fuse the scapho-capitate-lunate fusion.

Disputed Services:

Office visits, hot/cold packs, therapeutic activities, electrical stimulation, and supplied for the dates of 08/07/02 through 08/19/02, 09/06/02, 10/30/02 through 11/14/02.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the above-listed services and treatments were medically necessary in this case.

Rationale:

Physical therapy is needed for patients such as this. Therapeutic activities, physical therapy, and office visits for doctor follow-up were medically necessary. This was a re-operation of the wrist with some evidence of possible infection and breakdown of the fusion. The reviewer thinks this patient would need more physical therapy than normal.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,