MDR Tracking Number: M5-03-0268-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits and physical therapy was not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that office visits and physical therapy fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 4/29/02 to 5/14/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 23rd day of December 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

November 29, 2002

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0268-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on ___ external review panel. This physician is board certified in physical medicine and rehabilitation. ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 29 year-old female who sustained a work related injury on ___ while lifting a torch and twisting and turning her hand. She has been diagnosed with carpal tunnel syndrome. She has had extensive evaluation by multiple physicians and at least one chiropractor, various electrophysiological tests and extensive treatment by physical therapists and a chiropractor.

Requested Services

Electrical current therapy, special supplies, ultrasound therapy and office visits from 4/29/02 to 5/14/02, which were denied after peer review as being not medically necessary.

Decision

The Carrier's denial of authorization and coverage for the requested services is upheld.

Rationale/Basis for Decision

___ physician reviewer explained that this patient has had extensive evaluations, diagnoses and treatments delivered by multiple practitioners beginning on 11/6/00. ___ physician reviewer indicated that according to her physical therapy notes, she has had the same modalities in physical therapy ordered and delivered from 4/29/02 to 5/14/02. ___ physician reviewer explained that these records demonstrate that she had not previously responded to these treatments. ___ physician reviewer also indicated that the patient's symptoms were largely unchanged by all of her treatments. ___ physician consultant explained that even the improvements noted by the Work Hardening specialists have not resulted in a change in her symptoms or activities. ___ physician reviewer concluded that based on the lack of response to the treatment she received from November 2000 to April 2002, further physical therapy from 4/29/02 to 5/14/02 was not medically necessary for treatment of this patient's condition.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,